Exhibit 3

CONTAINS CONFIDENTIAL DOCUMENTS

Transcript of Costi D. Sifri, M.D., Corporate Representative

Date: September 5, 2024
Case: Phillips, et al. -v- Rector and Visitors of the University of Virginia, et al.

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
Charlottesville Division

DWAYNE PHILLIPS, et al.,
Plaintiffs,
- vs. -
RECTOR AND VISITORS OF THE UNIVERSITY OF VIRGINIA, et al.,
Defendants.

Civil Action No.: 3:22cv00075-RSB

CONTAINS CONFIDENTIAL DOCUMENTS

RULE 30(B)(6) DEPOSITION OF RECTOR AND VISITORS OF THE UNIVERSITY OF VIRGINIA, BY AND THROUGH ITS CORPORATE REPRESENTATIVE, COSTI D. SIFRI, M.D.

Charlottesville, Virginia
Thursday, September 5, 2024
9:25 a.m.

Job No.: 551154
Pages: 1 - 292
Reported by: Michelle L. Lonas, RPR, CCR

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Rule 30(b)(6) Deposition of RECTOR AND VISITORS OF THE UNIVERSITY OF VIRGINIA, by and through its Corporate Representative, COSTI D. SIFRI, M.D., held at the law offices of:

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Pursuant to agreement, before Michelle L. Lonas, Registered Professional Reporter, Certified Court Reporter, and Notary Public of the Commonwealth of Virginia.

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C O N T E N T S

E X H I B I T S

(Attached to the Transcript)

ON BEHALF OF THE PLAINTIFFS

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E X H I B I T S (C O N T ' D.)

ON BEHALF OF THE PLAINTIFFS

ON BEHALF OF DEFENDANT RECTOR AND VISITORS OF THE UNIVERSITY OF VIRGINIA

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P R O C E E D I N G S

(Witness was sworn by the reporter.)

MS. McGRAW: Before we get started today, this is Wendy McGraw on behalf of UVA, I'd like to just note for the record that Mr. Diehl is taking a video, which I understand is for his own personal use, not going to be released to the public in any way, and we're reserving all objections to any sort of use of the video in court. I'd also like to note that the witness is produced today pursuant to objections and designations that were made, and I'd like to just go ahead and mark as Defendant's Exhibit 1, Defendant Rector and Visitors of the University of Virginia's Objections and Responses to Plaintiffs' Notice of Rule 30(b)(6) deposition. And Defendant's Exhibit 2, Defendant Rector and Visitors of the University of Virginia's Objection and Responses to Plaintiffs' Amended Notice of Rule 30(b)(6) Deposition. So if we could mark these as Defendant's 1 and 2.

MR. DIEHL: Well, I didn't know you could mark exhibits, but I'll -- that seems all right with me.

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MS. McGRAW: Do you want copies, or --

MR. DIEHL: I'll take a copy, yeah. Yeah, that's fine. And if you want to mark those, just make sure there's a defendant's marking on those, and the initial -- so it's D-1 and D-2, and D-2 is the later document?

MS. McGRAW: Yes.

MR. DIEHL: We obviously don't agree with those objections, but I understand those objections exist, and we have different positions on that.

Do you want to mark those?

(Exhibits D-1 and D-2 were marked for identification and attached to the transcript.)

COSTI D. SIFRI, M.D.,

having been duly sworn, was examined and testified under oath as follows:

EXAMINATION BY COUNSEL FOR THE PLAINTIFFS

BY MR. DIEHL:

Q I introduced myself off the record, but obviously, my name is Sam Diehl. I am one of the attorneys representing the plaintiffs in a lawsuit against the University of Virginia. And can you

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please say and spell your name for the record?
A Sure. My name is Costi David Sifri, or Costi D. Sifri. Costi is C-O-S-T-I, D, it's D as in David, and then Sifri is S, as in Sam, R-I-F, as in Frank, R-I.
Q And I'll -- and you're a medical doctor? Is that correct?
A Yes, it is.
Q And I'll try to refer to you as Dr. Si -- and -- okay, I'm going to say it wrong I feel like. I'm all nervous. It's "See-free"?
A It's Sifri.
Q Sifri. Okay.
A Yeah.
Q I'm going to try to say that right. If I say it wrong, I apologize. Or if call you a -- if I demote you to a Mister, I'll -- I apologize for that as well.
A So I'm a Mister, and I've been called "See-free" before, and I'll answer to that as well.
Q Yeah. Yeah. People --
A So that's fine.

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Q No problem. And have you ever had your deposition taken before?
A I have not.
Q And so, I'll talk a little bit about depositions in general, but this is a somewhat of a unique deposition in that you're -- you understand that you're testifying on behalf of the Rector and Visitors of the University of Virginia?
A Yes.
Q And so throughout the day, if I'm talking about, you know, do you, or asking questions, I'm asking questions in your capacity as a spokesperson for the University of Virginia today. And -- do you understand that?
A I do understand that.
Q And if -- I will try to -- if there's some question sort of particular to you or your role personally at the University of Virginia, I'll try to say you personally, or something to that effect. But if it's ever unclear, will you let me know?
A I'll ask for clarification, yeah, when that comes up.

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Q Please do. So, depositions are, you know, somewhat similar to a conversation, so I'll -- I'm asking questions and you're answering questions. Obviously, it's a little different because there's a court reporter here taking things down. So because of that, it's important to answer questions audibly, and say "yes" and "no" instead of "uh-huh" and "uh-uh." Does that make sense?
A That does make sense.
Q And you're doing a great job so far.
And I will try to let you finish your answers, if you try to let me finish your questions. And Wendy will -- probably has warned you that sometimes I ask questions as I'm thinking, and so I will try to be -- to make the question fit within normal question timing, but just bear with me if I'm ever thinking and there's sort of a pause in there. But just let me know if I didn't let you -- well, let me just say this: If I don't let you finish an answer, will you let me know?
A Yes. And I will also work to make sure that you finish your question before I start to answer it.

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Q That's great. And is -- is there any impediment to you that you understand might inhibit your ability to testify truthfully today?
A No.
Q And if you don't understand a question, will you let me know?
A Yes.
Q And if, if you answer a question, is it fair to assume that you understood the question?
A Yes.
MR. DIEHL: What -- we're going to continue numbering, so I should have told you that before. We're going to continue numbering from the previous depositions. And I need to just double-check. Do you recall what the last number was?
MS. McGRAW: I don't. I also did not bring those exhibits with me, so I hope you have extra copies.
MR. DIEHL: I will -- and does the court reporter have the original exhibits? It's with the other court reporter? Williams Mullen has a scanner.

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We'll deal with that over lunch if we need to.
MS. McGRAW: Okay.
MR. DIEHL: I'm not too worried about that, so -- but I am going to mark -- I need to figure out what it was. One second here. (Pause)
So the last exhibit I understand was Exhibit 19, and so we'll start with Exhibit 20.
(Exhibit 20 was marked for identification and attached to the transcript.)
BY MR. DIEHL:
Q Do you recognize Exhibit 20?
A I do not. I don't think I've seen this before.
Q So, um, if you turn to the third page of Exhibit 20, there's an Exhibit A. Do you see that?
A I do see that.
Q And then do you see on the next page -- and Exhibit A starts with some definitions on page three of Exhibit 20. And then the next page, page four of Exhibit 20, is deposition subjects? Do you see that?
A I see that.
Q Does this refresh your memory, or looking

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at any of the next following pages, that you were designated to testify on the subjects that are listed -- or on some of the subjects that are listed on Exhibit A to Exhibit 20?
A Exhibit A to Exhibit 20? Can you tell me about what --
Q So the first page, we've marked this as Exhibit 20.
A Oh, oh, okay.
Q So that's Exhibit 20.
A All right.
Q And then there's an Exhibit A to Exhibit 20, which starts on page three of Exhibit 20. Do you see that?
A Yes.
Q And I'm really going to ask you about the deposition subjects beginning on the next page, Exhibit 4. Do you see that? Do you see those subjects?
A The subjects, deposition subjects, starting with number one, Every vaccine policy?
Q Yes. And have you seen this, these

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subjects before?
A Um, I'd be honest that I don't recall seeing this. I have seen documents, but I'm not entirely sure I've seen this exact one.
Q So, did you understand that you're designated to testify on certain subjects today?
A Yes.
Q And if we can go to the document that defense counsel has marked as Defense Exhibit 2, do you have that in front of you?
A I do.
Q And if you go to the second page of Defense Exhibit 2, do you see that you're listed there, and it says, Dr. Sifri will testify regarding the following topics: Topic 1, 2, et cetera?
A Topic 4 and 5, 14?
Q And you see those?
A Yes.
Q And do you understand that those topics listed on the second page of Defense Exhibit 2 are referred to, the subjects, or many of the subjects listed on pages four, five, six and seven of

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Exhibit 20?
MS. McGRAW: And while he's reviewing that, I'd just like to note for the record that the designation is made subject to the objections and the limitations placed in the Exhibits 1 and 2.
MR. DIEHL: Well, you've already put that on the record, so we don't need to do that again. But understood. I'm just trying to understand whether he's prepared to testify on the subjects.
BY MR. DIEHL:
Q Tell me when you've had a chance to take a look at those.
A Yes. I'm ready to testify on that.
Q Okay. So, having looked at Defense Exhibit 2, and pages four through seven of Exhibit 20, the -- there are topics listed under the bullet point one on the second page of Defense Exhibit 2. Do you see those different topics?
A Yes.
Q And you understand that those topics refer to subjects, deposition subjects numbered and lettered on pages four through seven of Exhibit 20, correct?

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A Correct.
Q And you're prepared to -- so, just going through those, subject one on page four of Exhibit 20, you are prepared to test -- are you prepared to testify on all topics except for Topic 1, lower case i; is that correct?
MS. McGRAW: Object to the form. There's objections to the topic, but he's prepared to testify subject to the objection.
MR. DIEHL: Okay, Wendy, we understand that the objections exist, and we're going to assume that those -- that you've made those objections. You don't need to repeat them throughout the day every time a topic comes up. I'm just trying to understand, it says, Dr. Sifri will testify regarding the following topics: Topic 1, except for 1(i). I'm just trying to understand if that's true.
MS. McGRAW: It says subject to and without waiving its objections.
MR. DIEHL: Okay.
MS. McGRAW: And it also says -- you're asking if he's going to testify about every vaccine

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policy. He is not.
MR. DIEHL: I didn't -- I didn't ask him that. I asked him about the subject one.
BY MR. DIEHL:
Q All right. You're -- have you looked at the deposition subjects that are on pages four through seven of Exhibit 20 at all?
A I've looked at many things, and I think I have looked -- I believe I've looked at all of these. But just right now in handing this to me, I wanted to make sure that I was truthful to say do I remember each of these? I was not entirely. I didn't want to commit to saying that without taking a look at this.
Q I guess, but have you seen Exhibit 20 before now that we've gone over it a little bit?
A I believe so. Yeah.
Q Okay. Subject to whatever objections, I'm not going to -- I don't want to go through that every time, because it will just slow us down, but we're going to assume that there are objections that have been made, and you've prepared in some limited way as instructed by counsel. But with respect to Subject

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1(a), what did you do to prepare for that topic?
A Um, I reviewed the UVA Health policies regarding occupational health vaccines and the development of, or the iterations of those policies, as well as, uh, um, having the discussions with counsel regarding preparations.
Q Yeah, and I'm not asking for -- throughout the day, I can't imagine that I would ever ask it, but if I am not -- I'm not asking for any attorney-client privileged conversations between the attorney representing the university here today. But I do want to hear about your preparations. So you looked at policies. Did you -- did you speak to anyone -- I guess, if it's easier just to not go through each lettered, lettered subject here, but with respect to subject one and the letter topics which you've been designated to testify, or subject to objection, you've mentioned you've looked at policies, and what else did you look at in terms of documents?
A In documents?
Q With respect to subject one and its, and its, the subjects there.

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A I took a look at, you know, the policy regarding occupational health vaccinations at UVA was a policy that started with our experience around other infectious diseases that dates back to when I started my position as the hospital epidemiologist in 2009, around pandemic influenza and other issues. And so I took a look at that experience, including a PowerPoint that I presented to hospital leadership, you know, during that period of time, when we had talked about some of the challenges and gaps in occupational health vaccinations in the early or mid, you know, 2014, 2015 time frame, and those documents that led to the development of the health system policy that is called OCH-002.
Q Anything else in terms of documents that you looked at to prepare for Topic 1 or -- yeah, Subject 1 or -- let me just say this: If I say "topic" or "subject," do you understand that I mean the same thing today?
A Topic and subject? Yes.
Q Okay. So with respect to Topic 1, any other documents that you recall reviewing to prepare

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to testify on that subject? With respect to Topic 1, any other documents you recall that you haven't mentioned that you reviewed in preparing to testify on Topic 1 and its subtopics?

A Yeah. So I took a look at Email exchanges regarding discussions around the development of, or the revision of OCH-002, again, the health care system policy for health care worker vaccination.

Q Throughout the day if I refer to the vaccine policy just as a shorthand for that OCH-002 policy, does that make sense?

A That's fine.

Q And I don't mean anything by that. I just, you know, it's shorter than saying OCH-002, occupational health, whatever the actual name is. Does that make sense?

A That makes sense. I'll also add the provision that I'll often probably just say OCH-002, because that's often what, how we refer to it, and it's baked into my language.

Q Absolutely. Absolutely. I just wanted to give you a definition that I might use.

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Anything else as far as documents that you reviewed besides some Email exchanges that you referenced, the policy, and documents related to the change in the policy?

A Um, I think those are the major ones. Yeah. I'm trying to think if there are other things. You know, I had -- you said other things. I had a conversation with Adam Momper, who was in the health system, and discussed, um, the vaccination, um, requests, requirements that occurred with our contract vendors. So, had a conversation with him, um, in terms of other -- oh.

Q What is Adam's last name? Do you know how to spell it?

A Momper, which I believe is M-O-M-P-E-R.

Q Okay. And does -- do you know what his title is, or what -- title or role generally?

A He is -- I don't know what the title is. His role is that he's, is an administrator that oversees procurement.

Q Okay.

A In that large role, a lot of the, you know, representatives of companies that come into the health system and provide services, those go through his, I guess, office.

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Q Did you speak to anyone besides Adam Momper?

A No, besides counsel.

And then in terms of other documents, um, I discussed the, um, PowerPoint that I used to discuss OCH-002. I also looked at PowerPoints of updates that I provided to hospital leadership, and one PowerPoint that I developed to discuss COVID to the hospital or health system auxiliary board, which I think is sort of a group that is invested and involved in the health system in different fashions, comprised, I think, largely of people from the public.

Q Is the auxiliary -- what is the role of the auxiliary board, to your knowledge?

A I'm not entirely certain. I was asked to give this talk to provide a COVID update. That was pretty common during the pandemic, that I talked to a lot of groups about COVID.

Q Anything else that you recall preparing, or as part of your preparation with respect to Topic 1?

A I think that's it.

Q So you've been designated, subject to objection, with respect to Topic 2 as it relates to undue hardship and medical exemptions I understand; is that correct?

A That's correct.

Q And besides what you, anything you did to prepare for Topic 1, is there anything you did to prepare for Topic 2?

A Anything in addition to what I did for Topic 1? No.

Q And you, similarly, same question with respect to Topic 4 as it relates to medical exemptions, as you've been designated. Topic 4 is on page six of Exhibit 20.

A No, nothing in addition to what I already stated.

Q And then, um, with respect to Topics 5 through 14, as you've been designated here, which are on page six and continuing on page seven of Exhibit 20, did you do anything else to prepare other

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than what you've already mentioned?
A Um, no, I don't -- no.
Q And Topic 17 really isn't a, it's a separate topic, do you understand that, on page seven of Exhibit 20? That just is asking about what we're going to ask about here, your preparation. Do you see that?
A Yes.
Q So, um, how -- of all the preparation that you did for today, whether meeting with counsel or reviewing documents or speaking with anyone else, how much time did you spend on that approximately?
A Um, I'd estimate maybe 20 hours.
Q And with respect to at least a number of these topics that you're designated to testify, you played a personal role in your position for the University of Virginia Health System in 2020 through say 2022; is that correct?
A Yes.
Q And as you've looked back on these topics, and prepared for today's deposition, and thought back on your personal role in any of this, what mistakes

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did the University of Virginia make?
MS. McGRAW: Object to the form, calls for speculation, calls for personal opinion, overbroad. Beyond the scope.
THE WITNESS: And so now I still answer.
MS. McGRAW: You still answer, but you're testifying in your personal capacity.
THE WITNESS: Yeah. Um --
MR. DIEHL: I don't agree. I don't agree. And to be clear, we're not -- this is not your individual deposition. We reserved the right to call the witness as an individual witness. I'm asking in his capacity as a spokesperson of the university.
MS. McGRAW: Well, it's beyond the scope of your request, so he can't testify as to that.
MR. DIEHL: He can't testify about the topics if they're negative? Is that your objection?
MS. McGRAW: No, he can't testify if it's not within the 30(b)(6) notice. If you want to ask him a personal question, you can ask him a personal question; he's sitting here.
MR. DIEHL: It's not a personal question.

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MS. McGRAW: Okay. You have the objection.
BY MR. DIEHL:
Q Okay. You can answer.
A Can you restate the question?
MR. DIEHL: Sure. Can you read back the question, please? And we'll assume the same objection.
(Last question was read back by the court reporter.)
A Great. So it's what mistakes did the University of Virginia make and what mistakes did I make, or -- well, I need to clarify that. Um, so what mistakes did the University of Virginia make? I think there were opportunities to better counsel the public, and that also, importantly, includes our team members about what to expect with any vaccine. And I think in retrospect, that is an educational effort that I think many entities, I think, had opportunities for improvement, and I would include that with our team. And I'm going back to early two thousand and -- or late -- early in the vaccine rollout period. So this is, you know, November, December 2020.

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In terms of the health system, I also think there was an opportunity to make COVID vaccination a requirement that was earlier in the course we ended up doing. So I think there was an opportunity to make it included in OCH-002, the vaccine policy, earlier, and advocated for that. And I advocated for that.
BY MR. DIEHL:
Q Anything else?
A Are we speaking broadly about all of COVID, or COVID vaccination?
Q Well, I'm speaking about the subjects that you're prepared to testify today, as you looked back through that, --
A Yeah.
Q -- did you see any mistakes that UVA made?
A So to those two points, yeah, I think those were the -- are probably the things that come to my mind. Highest on the list? I think there were opportunities for, you know, improving PPE use and efforts, you know, earlier that were very, very challenging due to supply issues. But I think that those are the things that are the foremost in my find.

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Q Stepping back for a minute, what is your current position with the University of Virginia?

A I'm a Professor of Medicine. I'm the Director of Hospital of Epidemiology, Infection Prevention and Control. And my medical specialty is Infectious Diseases, Adult Infectious Diseases, and I am the Director of the Immunocompromised Infectious Disease program.

Q Did you hold different roles -- so between 2020 and today, have you held different roles with the University of Virginia?

A No.

Q And what subjects do you teach as a professor? And I am asking you personally about this right now.

A So, the majority of my teaching is -- occurs during patient care with trainees, which would include fellows predominantly, but also internal medicine residents and some medical students in the care of patients who are hospitalized, usually hospitalized with infectious diseases. I, since the pandemic, have not had as much effort in the

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ambulatory care setting, so seeing patients in clinics. And then occasionally I have, you know, lectures, you know, in, um, either courses. That's not that often anymore, or, you know, didactic, what we call didactic lectures to residents, fellow, grand rounds, things like that.

Q And then what, you mentioned a role as Director of Epidemiology for the hospital? Can you -- what is that role?

A So hospital epidemiology is, is a, um, job designation where individuals who are usually infectious disease trained, not exclusively, but predominantly infectious disease trained, who work as probably the best analogy is the public health officer for a health system. There's -- you know, we have a, you know, a pretty wide breadth of effort, but it includes everything from reducing transmission -- efforts to reduce transmission of health care associated pathogens in the health care setting; um, promoting best practices is around things like hand hygiene, device -- health care device associated use. So that includes things like central lines or Foley

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catheters, which are indwelling bladder catheters, things that can lead to health care associated infections. We are subject matter experts on things like reducing surgical site infections, preventing nosocomial pneumonia, and then significant efforts around things like, you know, making sure that our practices and efforts are, you know, in -- our best practices are optimal practices as recommended by guidelines, and to be overseers of things like, um, you know, water quality in the health system, sterilization and high level disinfection. You know, things around, although, you know, medical products, pharmaceutical compounding. And as part of that, in apropos I think to this discussion, things like health care worker safety, although that also has a significant footprint or effort with employee health services or occupational health services, and, you know -- and patient safety.

Q And then other than the, your role as a professor and your role as Director of Hospital Epidemiology, is -- do you hold any other roles for the University of Virginia?

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A The medical direct -- although it's, you know, it's a title, Medical Director of the Immunocompromised Infectious Disease program.

Q And, I guess, currently, what amount of your time, approximately, do you spend on your various roles?

A So, um, I attend on the Immunocompromised Infectious Disease consult service for nine to ten weeks -- or ten to 11 weeks, I'm sorry, a year. So in that effort, I see patients who are hospitalized, who have had organ transplants, bone marrow transplants, have leukemia, lymphoma, and work with a team of at least three --

Q Yeah. I'm sorry. I just was asking about the amount of time. My question wasn't clear.

A Okay.

Q Just the approximate amount of time is -- maybe the percentage might be easier --

A Okay.

Q -- between the roles, in any given year. Well, I guess, in this year, what approximately do you expect the breakdown of your different roles to be as

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a percentage of your working time?
A So, um, it's about 15 to 20 percent clinical. I think it varies a little bit year to year, depending on weeks and days of the -- you know, hours of the day, so 80 percent hospital epidemiology. So the balance is epidemiology, with a small component of teaching.
Q And in, say, 2020 and 2021, was the hospital epidemiology role an even larger component?
A Yes. Yeah. Well, I think that because of the necessity of the pandemic, it certainly took as much or more time -- my clinical effort was the same, so, while the percents changed, the hours worked significantly increased, if that makes sense.
Q It does. And as part of your role -- well, do you work outside of the university?
A No.
Q Um, are you on any boards or work for any nonprofit -- or do any work with nonprofits of any kind?
A Um, so I do have a couple -- so I, um -- to go back for these last four years, I am on the

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American Board of Internal Medicine Test Writing Committee for Infectious Diseases. So that I think started in -- you know, I don't want to be inaccurate, but 2019 or '20, and I've been on that, served on that committee since that period of time. And that requires one to two meetings a year that are usually a two-day meeting. It used to be in person, now often virtual. And then in addition to that, I have served, although I've rotated off, on the Society of Health Care Epidemiology Association's Guideline Committee. So I did not develop guidelines, but was part of the committee that oversaw the development of guidelines, and I was, worked in that capacity for a couple years. Then finally, I am currently serving, and this is now year three, on the ID Week Planning Committee. ID Week is -- I should define what it is. ID Week is one -- is an infectious disease conference that's comprised of four professional societies: The Infectious Disease Society of America, the Society of Health Care Epidemiology, and then the HIV Medical Association, and Pediatric Infectious Disease Society. So it's our largest U.S. infectious disease

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conference, about 10,000 people, and so I serve on that planning committee.
Q And any other roles with nonprofits or other organizations that you are associated with outside of the University of Virginia?
A Outside, no.
Q Um, I've seen that you speak with the media with fair regularity. Is that a fair statement?
A I think that's a fair statement.
Q And that was -- was that even more true in 2020 and 2021, where there was news constantly about the pandemic?
A Yes, I think -- yeah, that is true.
Q Did -- it seemed like every state sort of seemed to have a -- Minnesota -- do you know Mike Osterholm at University of Minnesota?
A I do know Mike Osterholm.
Q And he was relied on by the news all the time as the go-to COVID guy. Were you -- to the extent -- well, I guess, did you seem to be the, for the media in Virginia, were you sort of a key spokesperson on COVID?

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A I don't know for Virginia. I think the university had a couple individuals, including myself, that were used for the very frequent media requests that were made to UVA. And as a hospital epidemiologist, I was often asked for that. I mean, it's -- I think Mike Osterholm has a national presence -- international presence, so I would not want to compare myself to him. But he is, you know, a well-known person. I can see that analogy. But there are others as well. But I did have a weekly designated media conference for much of this period of time from, I'm estimating, you know, sort of early 2021 for probably a couple years where I'd have a media briefing often with our CMO, Reid Adams. And that was on a Friday late morning. The reason I think for that was really to sort of control, in many ways, the frequent media requests, and so to provide an opportunity for the media to come and ask questions on a regular basis.
Q And CMO, what does that stand for?
A I am sorry. Chief Medical Officer.
Q And so Reid Adams is the Chief Medical

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Officer of UVA --
A Of UVA Health.
Q -- Health System?
A Yes.
Q If we say UVA Health, what do you mean by that?
A UVA Health System and UVA Health to me are si -- kind of the same. There was a rebranding that occurred at some point in the last couple years. But to me that is the UVA Medical Center, and some of the, you know, associated groups, since there's a School of Medicine, School of Nursing, the library, so -- Transitional Care Hospital, which is now closed, but that was part of the health system.
Q UVA Physicians Group?
A And UVA Physicians Group, yeah.
Q And UVA Community Health, I understand, was added more recently? Is that fair?
A That's -- that's correct.
Q Um, did -- with respect to its employment policies related to COVID vaccination, did UVA's role as -- well, let me just step back. Does UVA see

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itself as sort of a leader in public health issues?
A Um, I hope so. I believe so. I certainly feel that it has been and should be.
Q Is that a goal of you as, as Director of Epidemiology?
MS. McGRAW: Object, beyond the scope. You can answer.
A Um -- um, so yes. I don't -- the stammering is that I actually want to be clear about my division and sort of my view of UVA. I was attracted to come to UVA because of its well-known expertise in infectious diseases and the promotion of health of patients, people who are subject to infectious disease problems. Our division was founded by Jerry Mandell, the -- Dr. Mandell, who has now passed away. The textbook of infectious diseases is Mandell's Principles and Practices of Infectious Diseases, and I think that our division is arguably, has been one of the best divisions of infectious disease in the nation. There are many. I'm not going to say that we're the best. But it's a very storied and consequential infectious disease division.

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Q Do UVA's employment policies matter in any role that it would play as being -- as a leader in public health?
A So, again to go back, I think that Barry Farr, who was on our faculty and also is now passed away, was a founder of this field that we discussed earlier, hospital epidemiology. And a core principle of hospital epidemiology has been provider/health care worker safety. And I think that -- I feel that UVA, our division, and the hospital, and the health system, and our school of medicine have been leaders, yes.
Q I've seen a number of Email exchanges where different health systems or -- well, let me ask you. Were there exchanges of information regarding employment policies related to COVID vaccination between different health systems to your knowledge?
A Yes, I believe -- yes, there were.
Q Is there a specific group or a group of institutions that you communicated with regarding employment policies related to COVID vaccination in 2020 or 2021?
A There is a Email kind of ListServ where

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questions are often asked along those -- were, and still are, along those lines of all the efforts around COVID. To my recollection, I don't recall that that question was, like, there was a detailed ex -- you know, listing of health care -- of vaccination policies during that time. However, we were seeing, I was seeing, and efforts around the state, around with health systems adopting health vaccination policies in relationship to COVID and the COVID vaccine. And we would know and hear about other institutions often through, you know, Email exchanges, but actually more commonly through reports we would see in the media.
Q And you were on -- you were referencing an Email exchange or a group. You were on such an Email list?
A Uh-huh.
Q That's "yes"?
A That's yes.
Q Sorry. It's -- if I -- just know if I do that throughout the day, I'm not -- I understood what you meant if this were a normal conversation, but obviously, we're trying to get the court reporter

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to -- so don't take that as criticism. It just -- you're being a normal person, and we want you to be, you know, a deposition --

A Yeah.

Q Do you know how the list came about that you were on?

A The list that I, I do not know how it came about. I was included in that list probably 15 years ago. Its origin probably occurred much earlier than that.

Q What -- do you know what, was there a theme or type of institutions that were represented by the recipients of that list?

A I think it probably was heavily weighted towards academic health systems, medical centers, but not exclusively.

Q What's an academic -- you said academic health system? Is that the term you used?

A Yeah.

Q What is that?

A In my mind, an academic health system is one that usually would have a medical school, and most

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of those are associated with universities.

Q In Virginia, what academic health centers are there, or health systems are there?

A So, Virginia Commonwealth University, VCU, Eastern Virginia Medical Center, or Medical System, and then Virginia Tech.

Q Did the other academic health systems in Virginia implement COVID vaccinations policies around, at the same time as UVA implemented such a policy?

A I think, um, many of those institutions, but not all, implemented them before UVA.

Q When did the idea of mandating that employees be vaccinated for COVID, when did that idea come about at UVA?

A I think the active discussions occurred in May. Looking at notes, it may have come up as early as April.

Q When -- stepping back for a moment, when -- when, do you recall, did vaccines become available for UVA employees for the COVID virus?

A They came available the day after we got our initial shipment of vaccine. And I used to have

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this date committed to memory, but it was on or around the second week of December 2020. Our first vaccinations were in a group of six or seven frontline health care providers. That included a couple nurses, if I remember right, a couple housekeepers, and two physicians, and a nurse.

Q By -- by the time any discussion about a mandatory vaccination policy, by the time that discussion came up in April or May of 2021, do you know how many employees approximately were vaccinated in the UVA -- that worked for the UVA health system?

A There was a lot of work, as I recall at that time, to try to understand that number. It was really challenging, because of, you know, some of the reporting issues of understanding where people got -- you know, the fidelity of the data was challenging. But it was believed to be on or around 70 percent or so of health care providers, maybe even 70 percent had been vaccinated at that time.

Q And did you have information at that time, in April or May, that these -- that the 70 percent had primarily been vaccinated early, or had it been sort

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of throughout the six-month period approximately between December and May 20 -- December 2020 and May 2021?

A Yes. There was -- it was not a steady number. It was definitely a bolus number. Especially -- you know, so a lot of interest, effort, desire to get the vaccine early as it became available in end of December and through January. The vaccine also was a two-, you know, shot vaccine that was separated by three weeks. And so there was an effort to, you know, vaccinate these individuals, our team members, during this period of time, as well as pushing the vaccine out to other high-risk individuals during that period of time.

By May, we had opened up a vaccine center for, for the community, as well as -- I think most providers still got -- most of our team members got vaccinated on grounds. But by that period of time, the, you know, vaccination needs, slots were a lot more open. There was not as much of an effort -- I wouldn't say not as much of an effort, but not as much of a queueing in order to get the vaccine. So that

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vaccine center that was in one of the local shopping malls, Seminole Square, in an old Big Lots retail site, there was discussions to close that. And I can't remember exactly when that was closed, but it was summer-ish 2021.

Q The discussions -- so the discussions about potentially closing that vaccine center were early -- end of the spring, early summer.

A Right.

Q You said bolus. What does "bolus" mean for a simple lawyer?

A I'm sorry.

Q No, that's okay.

A So there -- so there was a lot of desire to get vaccinated, so a lot of effort with many people wanting to get vaccinated. We had, you know, a lot of desire to get, you know, from our team members to get vaccinated, and so that rush of people wanting to get vaccine was considerable in January. But as that initial group of individuals and we got to the 70 percent range, then certainly the, you know, the number of people needing, or seeking vacc, I should

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say -- not needing, but seeking vaccination in that May time frame had dropped off.

Q Fair to say that the majority of the 70 percent, approximately 70 percent of UVA Health employees that were vaccinated by May would have been vaccinated in December, January, early February? Is that fair?

A Yeah. Yeah. Or mid-February even. So there was a bit of a tiering system, you know, to -- it was, you know, get the nurses working in the COVID units and the physicians working the COVID units vaccinated first. There was considerations around other things like, you know, if people are, you know, involved in what are called aerosol-generating procedures, so anesthesiologists and anesthetists, to get those individuals vaccinated early, people in the emergency room sort of -- you know, trying to risk stratify COVID exposure in the health system to develop a queue to who got vaccinated first.

Q And I just want to -- well, how does, does COVID spread just generally? I don't need a -- I guess I'm trying to ask a question with -- you know,

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obviously we're not doing a scientific examination today, but I want to ask some questions about that. Well, I guess let me just set it up a little bit.

The -- any policies related to COVID and stopping the spread of COVID would, might, may depend on how COVID spreads; is that fair?

A Yes.

Q So, so in 2021, what did UVA understand how COVID might spread at any of its facilities?

A So, our understanding, I think this is consensus understanding, and it hasn't changed since then, except for maybe some nuances, but it's a respiratory pathogen that is spread by respiratory aerosols and droplets. And primarily by breathing those in or other inoculation of the mucosal surface. So, you know, your mouth, your nose, you know, the conjunctiva of your eye, the virus is able to get into your respiratory tract and cause infection. So the practices and policies around COVID prevention reflected that.

The nuance, I guess, is we also followed CDC guidance regarding health care worker protection,

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and so, again, the efforts around those would be, you know, from engineering controls all the way down to PPE. So by engineering controls, I mean things like air exchanges; the filtering system that's used in the hospital; at one time, sort of discussions around physical distancing. And then as you moved down from sort of the environment down to the person, things like personal protective equipment, which we followed CDC guidance around wearing masks, at that time eye protection, still -- I guess, still at this time eye protection, and then gowns and gloves.

Q You referenced CDC guidance. Well, you're not an attorney, correct?

A Correct.

Q Uh, and so I'm not asking you questions personally as an attorney, but did you understand, or did UVA understand the CDC guidance that you referred to, was that binding, or was it a suggestion?

A Yeah. It's always been a suggestion.

Q And then back to, back to the spread of COVID. So -- and tell me if I'm, this is a fair characterization as a layperson. Someone has COVID,

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they have contracted the virus, and then they have some symptoms such as coughing or sneezing or runny nose. And then that's -- that would be what would be the aerosol -- that discharge would be the aerosol or would propel the virus into the atmosphere? Is that fair?

A That is one way, yes. That's fair.

Q Did UVA find that -- what's -- to your knowledge, what's the consensus with respect to asymptomatic spread?

MS. McGRAW: Object to the form. You can answer.

A Okay. I think the consensus is that like other respiratory viruses I think maybe exemplified by COVID, transmission can occur when people don't have symptoms like coughing and sneezing that you had said earlier. And that was evident, you know, through epidemiologic findings that occurred, like transmission after, you know, singing and things like that. It's also worthwhile noting that sometimes people have mild symptoms that they don't recognize are infection, and so we call those people

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paucisymptomatic. So the mild symptoms that they may, you know, not be able to distinguish from hayfever or scratchy throat, because, you know, they think the air's too dry.

BY MR. DIEHL:

Q And at some point, UVA required some portion of the workforce to be -- to test for COVID on a regular basis; is that correct?

A That is correct.

Q And tell me -- tell me about that.

A Um, during, you know, for -- when vaccine requirements, or when the, when that vaccine was starting to be incorporated in the onboarding of new team members in the summer of 2021, if individuals were not vaccinated, then they were -- needed to undergo regular COVID testing. So there was a once-weekly test to see if they were potentially asymptomatically infected, or pre-symptomatically or paucisymptomatically infected. So all of those are potential scenarios: People don't recognize they have symptoms, they don't have symptoms, or they maybe are incubating infection or shedding virus and have not

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yet developed symptoms. It was a system that we were also using on the academ -- well, not we, but the university was employing on the academic side as well. And so it was, you know, informed by that and other institutions that had similar practices.

Q So with respect to the vaccine policy, OCH-002, that was initially changed with respect to new employees? Is that correct?

A That's correct.

Q And when was -- did you say when that change was?

A Um, I -- I believe it was --

MS. McGRAW: You can look at --

BY MR. DIEHL:

Q Okay. So, that -- so you've got a binder here today?

A I do.

MR. DIEHL: Do you have a copy of that binder, Wendy?

MS. McGRAW: No. It's just the copies of OCH-002 and the vaccine announcements, and actually one other document I think that he didn't mention,

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which is we had tried to print out a list of all the COVID policies and guidance for -- unrelated to the vaccine, because there was a really broad question about everything you did to protect against COVID. So he's got that in there.

MR. DIEHL: Okay. Maybe we'll make a copy of that at some point here.

MS. McGRAW: He could give you the Bates number too when he gives you the --

MR. DIEHL: Sure.

A I did take some notes on this just to make sure that I answered correctly, but it was on or around -- that's TD screening -- July 1st, 2021.

BY MR. DIEHL:

Q And, um --

MS. McGRAW: Can you give -- does it have a -- can you return to it? Does it have a Bates number on it, that number down at the bottom? Maybe give him --

THE WITNESS: Yeah. Do you need me to --

MS. McGRAW: If you could just tell him the Bates number so he has it.

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THE WITNESS: So UVA underscore 0000435.
BY MR. DIEHL:
Q And if I read Bates numbers, or you do, feel free to omit the leading zeros. It's just a little easier.
A Okay. So 435.
Q And can I just see a copy of that binder for a moment?
A (Tendered binder to counsel as requested.)
Q Okay. We'll make a copy at some point. I don't mean to highjack this. Outside at a break we'll make a copy. Thanks.
A You're welcome.
Q So you mentioned -- so the weekly testing that you were talking about with -- well, actually, there was one question that I had on terminology. We've talked about team members and we've talked about employees.
A Yeah.
Q I've seen -- I've heard those terms used by UVA. Is it -- am I right that "team members" might be a broader group than "employees," or is it the same?

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MS. McGRAW: Beyond the scope, but you can answer.
A Okay. So to me -- so I think that is correct. I think team member was a term that was developed as a sort of, you know -- I think sort of to, of -- how can I phrase this -- but a, you know, very forward thinking, inclusive, sort of a term for everybody that works in the health system. It was used to I think -- I think to sort of be a soft term for employee, to talk about, more about team building, to sort of reflect the values of the institution. But I think you're also correct, team members also includes people that are not employees, but people like students who are in the health care environment, or volunteers. It's a more inclusive term.
In, in the CDC for example, or in my field, we sometimes use the term "health care providers." And so I think that also is an almost equivalent term, although I think, you know, some would say as a volunteer health care provider, that's probably -- you know, and there may be some squabbles about that, but I think "team member" really tries to capture

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everybody that's in the health care environment that's providing services.
BY MR. DIEHL:
Q So for example, if you're a contractor brings meals around, you might not be providing health care, but you're a team member; is that fair?
A That's fair.
Q And with respect to the weekly testing that you mentioned, what type of tests were those?
A Um, so, um, there may have been different iterations. I think predominantly they were saliva testing, which was the program that was occurring at the time. There was also NP testing at some point, but I think it was predominantly saliva testing.
Q And -- and the idea -- what was the purpose of that?
A So, the COVID virus, SARS CoV-2 is in respiratory tissue -- respiratory -- in the respiratory tract and can be captured either through nose swabs, throat swabs, or saliva. All those tests have pluses and minuses, but they're all I guess -- I guess the purpose is to identify presence of the virus

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in the respiratory epithelium and secretions, or secretions.
Q If a virus is present, then that's when a person might spread the virus. Fair?
A If the test is positive, that suggests that the genetic material is there, and therefore, outside of the caveat of potential false positives, then they may have the ability to have virus that's transmissible to other individuals.
Q Did UVA measure the effectiveness of that testing in any way?
A Can I ask if you're talking about UVA Health, or the university?
Q I don't -- I don't know.
A Okay.
Q So I guess, did -- well, put it this way: Did anyone measure the effectiveness of the testing UVA was conducting weekly with employees who were unvaccinated?
A Yeah. I guess, one of the questions I would have is, you know, how do you measure the effectiveness? It would identify the individuals who

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had COVID, and so -- so to that degree, that effectiveness is seemed to, you know, identify individuals who unbeknownst to themselves were COVID positive.

To answer the question more broadly, the -- there was a broader experience at the university in using COVID testing to identify clusters of infections or outbreaks that occurred in dorms, and to put in mitigation efforts around those in order to maintain school operations that occurred prior to its use for employees of the health system.

Q So with respect to employees in the health system, is it fair to say that UVA found that testing protocol was effective in identifying employees who had contracted the COVID virus?

A I think it was effective. To say it was completely effective, I'm not -- I don't think you asked, but I think it was an important measure. It was -- it was beneficial. The challenge is that it was once-weekly testing, and with an incubation period of time of a couple days, you know, or as short as a couple days, it would be -- you know, would not be

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effective to identify every individual potentially who could have COVID because of that weekly testing cadence.

Q Do you know if that testing was expensive?

A My understanding is it was expensive, yes. It was -- and challenging from an operational standpoint. Individuals would have to -- you know, you have go to a laboratory, spit into a tube to collect the saliva. That takes times, time away from doing other efforts, like, you know, UVA providing health care. We can only process so many people in so much time. And I think also worth to note, it was -- we had a shortage of laboratory workers, just like shortages of nurses and doctors, and so the personnel to perform those tests and the reagents to perform those tests were in short supply. Plastic at one point was in short supply. This was -- you know, this was earlier on rather than 2021, but we were always concerned about it. Swabs were in short supply. We had to manufacture our own swabs, because the outbreak that hit, when it hit Italy, one of the two largest manufacturers of nasopharyngeal swabs could not

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produce any swabs because they were overrun with COVID. So we had continual supply chain challenges through the pandemic.

Q The shortage of workers, was that -- at that time in 2021, was that across the university health system?

A That was across the health system, yes.

Q Okay. Did -- did COVID make that shortage worse to your knowledge?

A Um, I think it did, both directly and indirectly.

Q How so?

A Um, so, individuals who became sick were not available to work. Um, individuals whose family members, let's say children were sick, had to stay home to help take care of them. And you know, I think everybody is familiar with sort of the, you know, the burnout that occurred during COVID. We had many individuals who left, you know, health care because of the challenge of taking care of patients through the pandemic. So, you know, it was both a supply and a demand challenge.

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Q Did UVA undertake efforts to try to alleviate that challenge, to your knowledge?

MS. McGRAW: Objection, beyond the scope. You can answer.

A Yeah, I wasn't involved in that, but definitely UVA worked I think tireless -- significantly to try to maintain a workforce to --

BY MR. DIEHL:

Q In terms of the expense of the testing that we were just -- that you were just talking about, the employee testing, do you know how expensive it was for a test?

A I don't.

Q Do you know if there was funding available from either the state or federal government to pay for any employee testing?

A Um, I don't. I do know that, you know, the health system received, you know, funds to help, you know, with the pandemic, the various, you know, emergency funding efforts that were made. But how those funds were distributed, I don't know.

Q Why -- when -- in April or May of 2021,

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when those discussions first -- or let me start over.
When discussions for, related to mandating vaccination for COVID started, and I think you mentioned April or May of 2021, what was the reason that those started?
A Yeah. They, I think, largely started for a couple reasons. One was that, um, a lot of -- you know, some of the issues were around workforce challenges, so we were having health care providers that developed COVID who, if they had not had COVID, they would be available to work. We also had the situation where following CDC guidance, if somebody was not vaccinated and were exposed to COVID, that they would be quarantined. And that could've -- that exposure could occur in, at work, but it could also occur -- that could be in the community. So if employee health found that a team member -- a team member said, I've been exposed to my son, let's say a family member that has COVID, that they would then not be able to work until they had completed a quarantine period.
We saw our team members, as I said, were

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getting sick, and we were concerned about that, especially since they were on the front lines taking care of patients with COVID. And importantly, we saw cases of COVID that occurred from patients who were in the hospital. And who were in the hospital for a long enough period of time that we were confident they acquired COVID during their hospitalization. So for those reasons, that's when I think these conversations started. So from my seat, it really largely occurred with that latter issue that we were concerned about our patient's well-being. But in addition, you know, I think those other issues around providing a safe, a safe workplace for our team members and to, you know, deal with the challenges of our workforce were also, I think, significant issues that were of concern at the time.
Q Tell me what you meant by "thinking about patient's well-being" with respect to the change in the policy?
A Yeah. So health care work -- health care acquired viral infections are well described, and so we had episodes where, again, if you saw -- a patient

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would be identified as having COVID after they had been hospitalized, and understanding where they acquired COVID, while challenging, not -- and it was rare that we ever determined that, we understood that they got it while they were in the hospital.
Q How did UVA determine that patients were infected with COVID while they were in the hospital?
A Yeah. So I'll give scenarios which may be more understandable. So if the patient's been in the hospital for a long period of time, and longer than the incubation period of COVID, so let's say they were in for several weeks, and then they developed fevers and respiratory symptoms or other issues that led to a COVID test during their hospitalization, then with the combination of a positive test -- and I can go into more detail, but a positive test with what we would consider to be a high viral load, if we were to take a look at something called the cycle threshold in terms of the PCR test, then we could determine that they had symptoms consistent with COVID, they had a positive test, they had a high viral load. And at that time, we were testing all individuals coming into the health

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system, and so we knew that when they were admitted they did not have COVID. So that combination of factors, COVID negative on admission, developing signs and symptoms consistent with COVID, and a positive test that occurs longer than the incubation period of COVID during their hospital stay, we can, I think, be confident in concluding that they acquired it during their hospitalization.
Q How did you determine -- how did UVA determine if they had received or contracted COVID from an employee or team member, or from another patient?
A That is challenging, and it depends on factors. So if the patient did not have visitors, and the patient was in a single room where they didn't have a roommate, then that would be consistent with getting, you know -- the likelihood is that they were exposed to a health care provider that transmitted COVID to them. It doesn't exclude, you know, rare possibilities like that they got it between another patient when going, for example, to a test if they were to go to, you know, to go get an X-ray or

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something like that. So it's very difficult to sometimes put these, you know, arrows, you know, on patients. But we, you know -- the likelihood would be if a patient was by themselves, not having visitors, that they acquired it, we feel, from a health care provider. We also had the precedence that this is -- these were seen in the past with flu outbreaks in hospitals and things like that.

Q Did UVA maintain any data with respect to its findings regarding transmission of COVID from employees to a patient?

A Um, can I ask for clarification? Exactly what do you mean in terms of data?

Q Well, I wouldn't know.

A Yeah. So we -- it was really all hands on deck, so we were really sort of in the practice that if we saw a cluster of infections, that we would address that in the moment, and, you know, see, you know, what's occurring on the unit. Are people wearing masks? Are patients, you know, being quickly identified who maybe had COVID and weren't being tested earlier during admission? It was really less

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of investigation of exactly what happened, but rather mitigation to see that we could, you know, stem a cluster of infections on a unit.

Q And I guess, did anyone write down information that was learned in any of these instances you're referring to?

A Um, you know, in -- we would have, you know, like a line list of -- we call them line lists. So we'd have a list of patients, and, you know, when they were positive, and -- or maybe a summary of those patients.

Q So a summary of patients who were believed to have contracted COVID from an employee or a team member?

A No. A summary of patients who developed COVID during their hospitalization.

Q And did -- did UVA make some, a finding of some kind that there is a material concern related to employees transmitting COVID to patients because of the data we're seeing or the situations that have occurred?

A I think the -- I think what I described is

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what would occur if there was the recognition that there was a group of patients and/or employees in a location, then we would work with a manager, let's say, or with other people on that unit and say, We've seen a cluster of cases here, and then address, What do you think is happening? So we always start with questions? Are there visitors? Are people wearing masks? You know, what are the practices around, you know, protection, COVID mitigation, that are occurring on that unit at that time?

Q That collection of information that you're referring to, was that information -- well, let me step back.

You're referring to conversations that were occurring when you say -- you know, when you're talking about this situation?

A Uh-huh.

Q Is that correct?

A That's correct.

Q And did anyone write that information down and try to track what was occurring?

A Not -- not systematically.

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Q Did UVA make any finding that with respect to transmission of COVID at, at any UVA facility, that there was some connection between vaccination status and transmission of COVID in the real world at UVA Health?

A Yeah. No. There -- it was so busy that we were not doing that. And for the most part, actually, in all instances, we would not know vaccination status of the team members, or health care providers, you know, in these events. That was information that was not, you know, privy to us.

MR. DIEHL: I didn't say this at the beginning, but if you ever need to take a break throughout the day --

MS. McGRAW: Yeah, we've been going a while. This would be a good time.

MR. DIEHL: I was going to say, it's probably a good time for a break. But again, if that occurs later, if you feel like you need a break later in the deposition, just let me know.

THE WITNESS: Okay.

(Recess taken, 10:49 a.m. to 10:59 a.m.)

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BY MR. DIEHL:
Q All right. We're back on the record. We just took a short break, and we also tried to get some copies related to the binder that the witness brought today. I'm going to mark that binder as it exists right now as Exhibit 21, and then we'll come back to that later once I have a copy as well. Yeah, might as well go ahead and mark it just so that we have it marked.
(Exhibit 21 was marked for identification and attached to the transcript.)
BY MR. DIEHL:
Q And if -- you're welcome to refer to the Post-It notes, but if you could just keep them in there, you know, throughout the day. Just leave them where they are. And obviously, if you need to look under them or something, that's fine.
So we were talking about the reasons for, or we started to talk about the reasons for implementing a change in policy, OCH-002. And we were talking about one of the reasons was to prevent patients from contracting COVID. Is that fair?

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A That's fair.
Q And with respect to that, that reason, that particular reason for the change in the policy, what data did UVA have that would indicate that that change was going to be helpful in preventing the spread of COVID to patients?
A Um, you know, so, um, you know, the first thing is experience with respiratory viruses. So UVA, and I think, more broadly I think in our field of Hospital Epidemiology, Infection Prevention and Control, there's experience understanding that improved vaccination reduces health care associated infections in patients, as well as reducing health care provider to health care provider transmission of the virus in the health care setting. Some of that research goes back pretty far, back to the, you know, 19 -- late 1980s to 1990s. There is a seminal paper that was performed from work at UVA that showed that improved COVID vaccination in health care providers reduced health care associated or what's sometimes called nosocomial health care associated influenza in patients, as well as reducing health care acquired, or health care worker laboratory-confirmed flu.
So I referred to Barry Farr earlier. He was -- his work was, was cited -- that was his work, and that is often cited as some of the evidence that supports health care worker vaccination for influenza. And during that period of time, my recollection is that started, um, with the observation of health care associated influenza that led to pneumonias and patient death or more. So there's that experience, that respiratory viruses in the health care setting can be transmitted between patients, between providers and patients, and between patients and providers, and that those are important factors in the reducing and stemming influenza transmission in the hospital.
And prior to this pandemic, there had been significant efforts around influenza vaccination with adoption pretty significantly across the country of these requirements for influenza vaccination amongst health care workers. So there was that precedence, and that was with a vaccine that is about 50 percent protective for influenza infection. So, what evidence -- so the evidence, if I -- just to rephrase -- not rephrase, but to repeat what you asked me, what evidence did UVA have that improved COVID vaccination would reduce COVID infection within patients, and I think -- I don't know if you asked that, but also between providers, at that time, we didn't have direct evidence. I think that that would happen, but we had, and I had, the experience of understanding that if you do things to improve the net state of immunity of a health care worker population, that that can improve, um, or at least, stated differently, reduce the risk of transmission of virus between patient -- between health care providers and patients, and between health care providers to other health care providers in the workplace setting.

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Q The -- the information that you're referring to in the past, or before the COVID vaccines were available, that -- those were all vaccines unrelated -- let me -- that was a bad question. I'll object to my own question.
With respect to the studies or information you just referenced in your answer, that would be information related to other vaccines? Is that fair?

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A Yes. To other vaccines and to other viruses, yes.
Q The flu vaccine, for example?
A The flu vaccine, yes.
Q What other vaccines are you referring to that -- which vaccines were the subject of the information you referenced?
A You know, I think measles would be another one, but maybe perhaps a little bit more of a stark contrast. But measles is --
Q So, I'm just asking for the vaccines, which vaccines.
A The vaccines? Okay.
Q I don't mean to cut you off, but I don't -- maybe we want to talk about that. But which other vaccines specifically were you referencing? So measles? Flu vaccine? Is that correct? Influenza?
A So influenza with the flu vaccine, measles that's provided through the MMR vaccine, and pertussis would be another good example.
Q What is, is pertussis a virus?
A Yeah, whooping cough. It's a bacterial

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infection actually. That's not a virus.
Q And did any of that information compare the value of -- well, let me ask you a different question.
UVA had been having unvaccinated employees test on a weekly basis. Did any of the information that UVA had in 2021 indicate the relative preventive value regarding the spread of COVID between vaccination versus weekly testing, for example?
MS. McGRAW: Object to the form, but you can answer.
BY MR. DIEHL:
Q Well, do you understand the question?
A I understand the question.
Q So just so it's clear, you know, we've been talking about weekly testing. You recall that?
A Prevalence testing.
Q Well, weekly -- that prevalence testing would refer to weekly testing of unvaccinated employees for the COVID virus?
A Yes.
Q And so did UVA have any data or studies that it could draw on with respect to the relative

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value in reducing prevention -- now, I can't say the words.
Did UVA have any studies or data in 2021 that would indicate the relative value in preventing the spread of COVID between vaccination for COVID versus weekly testing?
A So we did not. We did not have any internal information regarding that, and, um, we did not have, and I cannot recollect to you even now at this time that there was information like that available in the medical literature of a comparison between what you've just described. If I can expand, it is often in the case in a pandemic, but also often with these real world examples of things that we deal with, that we were implementing multiple mitigation efforts at the same time. And so parsing the relative benefit of one versus another is very difficult, because usually you're doing multiple things at the same time. And in our world, we often call that a bundle of interventions. And so that's commonplace with things like central line infections or surgical site infection prevention. I shouldn't say central

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line infection, but central line infection mitigation or prevention efforts.
Q Fair to say any prevention effort might have potential negative effects or downsides for, to use a broader term?
MS. McGRAW: Object to the form. You can answer.
BY MR. DIEHL:
Q Well, do you understand -- do you understand what I'm asking?
A I understand exactly what you're asking. I think, yes, all mitigation efforts have potential benefits and potential costs, and those are things that we consider when doing implementation.
Q So with respect to adding the COVID vaccine as a mandatory vaccine for team members in 2021, what potential costs did UVA weigh?
A So the costs, um, let me just think about that a second. That the costs would include cost of vaccine. The efforts around providing that additional vaccine in terms of manpower to provide the vaccines. The significant administrative lift to make -- to go

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through the process of, you know, tracking down all of the team members that needed to meet those requirements, and go through that process of, you know, encouraging vaccination, and the timelines involved.

Um, there is also the challenge of, you know, making sure that you're applying this, um, requirement fairly and broadly across all, um, affected health care providers, team members, and in -- you know, so -- you know, making sure that things are aligned between, you know, physicians who maybe have a -- will have a different reporting structure than let's say nurses or therapists, or, you know, medical and nursing students. Those are all, you know, governed or sort of, they're -- the reporting structure is different amongst those different groups in making sure that those processes are aligned and fair.

Q Any other potential costs that were considered?

A There is always the concern that we would cause health care worker team member dissatisfaction

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about requirements. That was judged significantly by, you know, during this process by, by leadership, you know, understanding that that could lead to dissatisfaction amongst, amongst some team members. So that was a concern.

There's a concern, I think, you know, you know, that that may lead -- you know, would that be looked -- you know, either as a pro or a con amongst individuals in the community, and so that's -- that would be sort of what's the community perception of those efforts. Um, I'm trying to think of other things that I may not have expanded on.

I mean, I -- you know, the health system is part of the broader university in making sure that the, you know, that these decisions were in line with, you know, I think other leaders in the university and in the state. We had, you know, governing bodies, or not -- even not governing bodies, but practice associations, things like that. You know, are we, "we" being UVA, is UVA, you know, acting in a way that is consistent with the way other hospitals and health systems are approaching mitigation of the COVID

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effort?

Q Explain that a little bit. What do you mean by consistency with other systems?

A Um, you know, is -- it would be, I think, a potential challenge or tension or, you know, I think that if -- that we were -- UVA was not doing things that potentially -- or is not aligned with another organization, let's say another hospital in the region. So, I think that, you know, leadership was also often involved in conversations to see what other institutions were doing around things like this. I know for a fact that they were doing that around things like visitation. So, for example, you know, how many visitors are you allowing in the institution? You know, what are your requirements for visitors who are coming into the health system? Where are they allowed to go? What ages are they? You know, to make sure that -- I don't want to say to make sure, but to understand what UVA practice was, it was helpful to know that it was balanced compared to other institutions, not out of line. There was a lot of discussions from those, the people that sort of

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oversaw those efforts to see that our practices were reasonably similar to others. Of course, there's going to be local variations and differences reflected in, you know, maybe university -- or not university, but community norms, maybe the impact of the, you know, what was occurring with COVID in the community at that time, and things like that.

Q Who -- when you referred to leadership, I guess, who -- what leaders of UVA Health were involved in decisions related to COVID vaccination policy changes?

A Um, so, the -- I think it was, um, a process that was led by Craig Kent, the EVP of the health system, and included, you know, members of, of the Chief's Office. So the CEO, Wendy Horton. The Chief Medical Officer I mentioned earlier, Reid Adams. We have a couple Chief Nursing Officers. And I think the leads of our Schools of Medicine and Nursing, so the deans. So, that group, so cabinet, and the heads of the other entities of the -- and I should also mention, the head of University Physician's Group, Dr. Chhabra, I think were, you know, the core group of

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individuals that were involved in this decision-making process.

Q And those leaders would include you personally as well?

A You know, I know I'm named in these. I'm not -- I feel as a hospital epidemiologist I'm more of a subject matter expert and advisor. But I know that I'm named in these, and so -- so I think in terms of this decision I would be considered a leader in that. But, you know, I'm not a member of the -- I'm not a chief of the hospital. I'm a subject matter expert.

Q So to use a different phrase or something maybe, there were other deciders, but you would provide information and answer questions for the deciders? Is that fair?

A I think that's fair.

Q With respect to the change in policy in July 20, 2021, related to COVID vaccination, and then there was -- well, let me just step back for a second. There was another change in August, that was announced in August 2021; is that correct?

A That was announced in August, yes.

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Q It was announced in August.

A Yeah.

Q And you're referring to that's when it was not just for new employees. It was for all employee -- all current employees would have to be vaccinated by November, some date in November 2021.

A Correct.

Q And with respect to those decisions, were they decided at the same time, or were they decided separately in the, in sort of the sequence that they were announced?

A Um, from my perspective, they were -- they were decided sequentially. I don't recall being in the room, and I'm not certain if there was a room where it was ultimately decided, but my recollection -- my understanding, I shouldn't say recollection -- my understanding is that, you know, that first step of requiring vaccinations for new health care providers that were being employed, you know, on or after July 1st, that that was a first step. Um, and um -- and I did not hear a commitment at that time to say we will do, you know, require

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health care -- we will require all health care providers, all team members to get vaccinated. I was advocating for that, but I did not hear that commitment.

Q Do you know how that conversation started? The conversation about changing the policy to require COVID vaccination either for new employees or for current employees?

A I don't know how the conversation started. I know that I started raising that as an issue, you know, in May, and perhaps early April -- or not -- late April, but in that time period, in the late spring of 2021.

Q So you started raising the issue, and then do you know how that conversation changed to let's do this, or how that came about?

A Um, I don't know how that came about. I do distinctly remember the time I think I first raised it, it was during a conference call. And, you know, these were one of the executive conference calls that included the members of, I'll call it Dr. Kent's leadership team, and, you know, said this would --

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this is going to be a discussion I foresee. I can't recall at this time whether other institutions had reported their move to requiring vaccinations yet or not, but it was around that time that we had heard that a couple other hospitals in the nation had moved to requiring health care provider vaccination requirements. And, um, so I raised that issue, and I think there was, you know, sort of a yes, this may be something we'll have to think about, with in fact some of the caveats that I think you brought up earlier -- or not that you brought up, that I brought up, that I think you -- your questions led to, which was what would this -- what would our team members think of this? Would this lead to dissatisfaction? What would the potential costs be in terms of health care providers that may decide to leave the institution rather than get vaccinated?

Q You -- what is -- who would be -- you referred to Dr. Kent's leadership team. Who would that be?

A I think it would -- not I think. It includes the individuals that I saw named here in this

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document.
Q What document's that that you're referring to?
MS. McGRAW: You can just give him the title.
A Oh sorry. Defendant UVA's Amended Answer to Plaintiffs.
BY MR. DIEHL:
Q Let's -- let's just mark that as a new exhibit. And I believe it will be Exhibit 22. If you want to mark the copy that the witness has, please, I will --
(Exhibit 22 was marked for identification.)
BY MR. DIEHL:
Q So we marked Exhibit 21. Or is it 22?
A Twenty-two.
Q Exhibit 22. I'm sorry.
And that's UVA's Amended Answer to Plaintiffs' Interrogatory Number 1. And then at the end that's dated September 4th. So there's a Certificate of Service that's the last page of that that says 4th day of September. Do you see that? I

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just want to make sure so I've got the same full document you do.
A This one right here?
Q Yeah. Counsel's pointing. That --
A And your name, and the Certificate of Service, yes.
Q And it just -- I just was trying to check that since it doesn't have a Bates label or a page number. That last page says, I certify that on this 4th day of September, 2024 -- do you see that? Sorry. It's -- the double-sided is -- can be confusing.
A If you wish to -- if you wish to show me where you --
Q How about this. I'm going to just mark a new exhibit, because I hate double-sided exhibits.
MS. McGRAW: I'm sorry.
MR. DIEHL: Let's just -- let's just cross that off. So we're not going to use that Exhibit 22. I assume there are no markings or anything on that. So we'll just use a new one. It will be less confusing for me and the witness I think.
THE WITNESS: I apologize that I did not

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see where you were referring to.
MR. DIEHL: No, it's all right.
THE WITNESS: I saw the September 4th.
(Exhibit 22 was remarked for identification and attached to the transcript.)
MS. McGRAW: I think -- I think it's my fault, because there's no page numbers on it.
BY MR. DIEHL:
Q There are no page numbers, which is okay. But I'm just trying to sort of get a sense that we're looking at the same document. But look at Exhibit 22. And if you could look kind of through the, flip through the pages and make sure that's the same document you were just referring to that you brought to the deposition today.
A Yes. And the section that I was referring to in terms of leadership team is under Amended -- sorry, a fly -- Amended Answer -- sorry. That's not very nice of me. Amended Answer to Inter --
MS. McGRAW: Interrogatory.
A -- Interrogatory, thank you, Number 1. So Craig Kent, Wendy Horton, myself, Costi Sifri, Bobby

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Chhabra, Pam Cipriano, Mitch Rosner, Mitchell Rosner, David Wilkins. So this includes those individuals.
Q And did the leadership team include anyone else besides those individuals that are referenced in the Amended Answer to Interrogatory Number 1?
A So the meeting I was referring to was a Zoom meeting, and I anticipate there were other individuals on the call, um, you know, from, you know, other parts of the university. It wasn't huge, but I can't speak to exactly who those people were. But I would -- I think that I can say that this included -- that this was, is what I'm referencing in terms of his whatever I got, a leadership team.
Q Do you know if UVA Health records Zoom meetings?
A I don't think they do. I'm not aware that they record Zoom meetings.
Q And have you ever used the Chat feature in Zoom meetings, where you can chat to one or more participants in the meeting?
A Yes.
Q And that would --

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A But I -- I'm sorry. I didn't use the chat during those meetings, and I don't recall it being used during those meetings.
Q You specifically recall that?
A Yeah, I specifically -- I recall that I did not use the chat during those meetings, because I don't usually use those, use the chat function in meetings.
Q Do you know --
A Plus -- I'm sorry?
Q Finish your answer.
A But plus, I was -- the structure of most of those meetings is they would often start with me providing an epidemiologic update of the pandemic, and I would go through a set of PowerPoint slides. My effort and attention was towards that, and not monitoring a chat.
Q And do you know if anyone else on those leadership meetings ever used the chat function?
A I don't know.
Q Do you know if -- do you recall -- the specific meeting we've been talking about, about where

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the idea of implementing a mandatory vaccination policy either for new employees or current employees, did you have a PowerPoint presentation at that meeting?
A I anticipate that I did.
Q But you don't recall the specific date of that? That's a meeting that could have occurred in late April, early May?
A April, May I think is correct.
Q And do you recall how the conver -- any conversation related to a mandatory vaccination policy came about or occurred?
A Yeah. Um, my recollection is it occurred in the context of the observation of team members that were, um, out either sick or being furloughed because of COVID exposure. It was in the context of that.
Q So the idea was, just that initial idea, was that by being vaccinated, employees will be out less, or be out sick less, or for shorter periods of time? Is that fair?
A I think that's fair.
Q Was there a discussion at that time about

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other hospital systems and what they were doing?
A I don't recall that coming up in that context.
Q Is there -- is there someone on the leadership team that is more plugged into conversations with other health systems than you are?
A Yes. I think it's fair to say probably, um, Wendy Horton as the CEO, and Reid Adams perhaps, as the Chief Medical Officer, were more plugged into what other health systems were doing, at least regionally.
Q And what do you recall about conversations with other health systems that specifically related to changing UVA policy related to mandatory COVID vaccination?
A Um, so if we're talking about this time frame, April to May, I don't recall any specific like, um, conversations, or hearing about conversations like that. I know in the Email notes that later on, um, you know, that there were -- there was a recognition of what other health systems were adopting in August. And I think I referenced earlier that in the -- you

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know, sort of in the, you know, in the public domain there was understanding of what was occurring in terms of vaccine requirements at, I recall, Medical University of South Carolina as being an earlier adopter.
Q And you touched Exhibit 21 when you referenced an Email I think a moment ago. Were you referring to something that is an Email that's included in Exhibit 21?
A No.
Q Okay. I saw an Email -- well, do you recall any Email where there was a discussion about, you know, it's almost like we agreed on the date or something like that. Was there -- do you recall any agreement between health systems on implementing a COVID vaccination policy?
A No, I don't recall. In fact, I recall the opposite, that there was not agreed dates about when to implement. There was checking, What are you doing? What's your policy? But I don't recall any, in fact, again, the opposite, if there was any decision, we will implement it on X or Y date.

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Q And was -- what was the purpose of checking again? You might have said this earlier, but I don't recall what -- if you did. But what's the pur -- what was the purpose of UVA's leaders checking with other health systems with respect to changes to its COVID vaccination policy, or to implementing a COVID vaccination policy?

A I can't speak for why others were doing that, but I'm going to hypothesize. Part of that was wanting to know if they were enter -- you know, planning on doing that, that they weren't an outlier. I think the other issue would be to understand what the impact was. You know, what were the costs, as you said, of those policies? How -- how did the health care providers react? What was -- what were the challenges that occurred regarding implementation of that type of policy?

Q With respect to being an outlier, is the idea -- what would be the problem or the benefit, either benefit or problem of being an outlier?

A I'll preface it by saying that I think -- I feel you should -- oh boy -- I feel you should -- I

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feel that -- I advocated to, that we should do what I felt was the right thing to do; that it was okay to be an early adopter, for example. Not only okay, but I would advocate it would -- that we felt that the situation was such that it was justified that we should do so. I think that leadership or others may have felt that if they were, you know, not, um, in step with what other institutions were doing, that they could be -- there could be criticism from some quarters, I'm not sure whom, but you know, from health care providers that were employees that they were being imposed on to do, you know, to do things that other institutions were not requiring, as one example.

And it's also fair to say, you know, to state the obvious, the vaccine, you know, in some, you know, circles, and is, a very unpopular idea, and so that there is, I think, significant concern about, you know, the consequences of making that decision. Those were not challenges that we would have had, or had to face in the past with things like the flu vaccine or the MMR vaccine, at least to that extent.

Q Was there any discussion about why the

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COVID vaccine was unpopular?

A Um, in that forum, I don't recall that being a topic. But it feels like it's general knowledge, common knowledge that, you know, that there are individuals that are concerned, and, um, about the vaccine for a host of reasons that many of us worked to try to address as hard as we could.

Q In 2021, I guess, what were the reasons the vaccine was unpopular?

MS. McGRAW: Object to the form. You can answer.

A Okay. Um, so we'll kind of step through it. So there was a perception that it was developed so rapidly that there were concerns about its safety, um, in some quarters. That, you know, as my seat in my role, and I think in following, you know, what we knew as ID physicians and public health officials, FDA and CDC felt that, and still feel to this day, that the benefits of the vaccine far outweighed the harm. The branding of it as a quickly developed vaccine, was incorrect. This was a vaccine that came out of decades of research of mRNA technology. And that is

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just one of the vaccines that was developed as part of this vaccination effort that was funded by the U.S. Government. There were, to my recollection, five or six different candidate vaccines, three of which came to market in the United States, you know, on or around, you know, the late 2020, early 2021 period, with two different platforms, mRNA, and the vector based vaccine. And then following that, other types of vaccine technology, like protein based vaccine technology. And of course other places around the world had different approaches.

So, um, it -- you know, that was certainly a concern amongst some quarters, that it's a new virus. We don't understand it. New vaccine platforms. And you know in terms -- I don't think that it was -- when you talk about, you know, opportunities or, you know, challenges early in the pandemic, I think branding operation warp speed was not helpful, because that led to a perception that appropriate safety checks and oversight were not performed, which was not the case.

And then we need to understand that, you

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know, I think it's a natural human inclination not to -- you know, for, amongst meany people, not to have new things used for them. There are, you know, people have that -- can have that reaction. So that was a concern as well.

And then finally, I alluded to this earlier, there became, um, you know, sort of a perception that I think developed some political overtones about, about vaccination, um, and/or this specific vaccine. So I think all of those were things that I think played into, um, vaccine hesitancy. But we need to understand, vaccine hesitancy is something that occurs with all vaccines, not just around the COVID vaccine, vaccines.

BY MR. DIEHL:

Q So just to, I guess summarize, you talked about concerns related to perceptions about safety, and the vaccination's -- or the vaccine's development; is that fair?

A That's fair.

Q As kind of a category of concerns. And then you talked about political overtones and

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political concerns as another category. Is that fair?

A That's fair.

Q Any other concerns besides safety and political concerns related to the COVID vaccines that might have led to unpopularity or hesitance of employees and being vaccinated?

A I also alluded to sort of just general hesitancy, and I think there's sort of an autonomy concern that comes with things like vaccination. So that's included as well.

Q Anything else besides those things that you mentioned with respect to concerns that employees had that led to hesitancy of being vaccinated for COVID?

A Hmm. Well, as autonomy, also corollary to that is mistrust, I guess. Maybe that's mistrust not only like of the health system, but more just mistrust I guess of, you know, the scientific process of vaccine development perhaps. And then there was mis, you know, misinformation that feeds into those things like, you know, is it going to change our DNA or something like that. You know, are they implanting something that could be used to track me? So those, I

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think, are appropriately labeled as misinformation, not true, that those feed into narratives of mistrust of the vaccine, of vaccine development, and, you know, or I guess those that are advocating for vaccination.

Q Any other misinformation that you recall? You mentioned, you know, might change my, someone's DNA, or that might track me as getting the vaccine? Is there any other misinformation that you're aware of that was kind of causing employee concerns in 2021?

A I will step back and say that I don't recall that I heard team members that raised concerns of tracking, or changing my DNA, you know, in terms of their personal vaccine hesitancy. I was speaking more broadly as an Infectious Disease physician and knowing these narratives and hearing of these reports. And specifically, I don't know of other concerns or themes of concerns that team members brought up.

Q Was there misinformation about fetal cells out there, or fetal -- anything related to abortion or fetal cells?

A I think -- um, my understanding, yes, is that there were individuals that felt -- or that

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were -- thought that the vaccine contained fetal cells.

Q And it -- and it did not?

A And it did not.

Q And were there any other concerns related to fetal cells or abortion in any way that you are aware of?

MS. McGRAW: I'm going to object that we're going beyond the scope if we're getting into the religious exemption process, but he can answer.

BY MR. DIEHL:

Q Do you recall, I'm talking about misinformation that you were just talking about. I'm just wondering about other categories of misinformation. Does that make sense?

A It does.

Q Okay. So with respect to fetal cells, anything other than fetal cells being in the vaccine that you recall?

A As far as misinformation. I don't -- I can't think of another, you know, like things in the vaccine, no. I know there was concern, um, about like

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egg products being in the vaccine, or protein being in the vaccine from, like, gelatin or animal cells. So individuals that had egg allergies, or alpha-gal, which is an allergic reaction to animal protein to beef that arises after people get tick bites, there were concerns that the vaccine would contain those, and they don't.

Q And so I guess more broadly, the last several questions we've been talking about, you know, reasons why people might have been hesitant in 2021 to get the vaccine. Is there any hesitance that you're aware of in 2021, besides what we've just talked about? Or stemming from an issue that we have not talked about, I guess I should say.

A So, again, broad, broadly, I think -- well, to talk about within health system and health care providers, not that I know of. I know that sort of a theme that's been recognized since and -- during and since this period of time is that, you know, two things come to mind: One is people's perception. And I don't know if there was misinformation per se, but just perception that COVID was not a big deal. I

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don't think that that was a theme I heard within our team members who were on the front line seeing patients and seeing the consequences of COVID. But I think that that was something that was seen elsewhere; that COVID was not a big deal, and that it was just another respiratory virus, another flu, and was not causing the number of deaths that it was, or that that was consequential to society. And I think individual's perception of their individual risks to COVID, that's something that people that tell me about, but is also, I think, well-recognized that if individuals don't think that they are at risk for COVID, they were less inclined to get a vaccine.

Q Were these issues related to vaccine hesitance and -- hesitance in receiving the vaccine, were they discussed as part of UVA's decision-making process to change its policy to require mandatory vaccination?

A No. I don't recall them being discussed specifically about changing policy, other than just sort of an aggregate understanding that -- you know, that we'd received -- it had gotten to a point of

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health care provider vaccination that was sort of reaching a limit, or sort of wasn't increasing significantly. It was more of a discussion that occurred when we worked in the community to help provide vaccines to the community. And, you know, that's -- when I say "we," you know, it was -- I was involved in those efforts, but significantly across the health system, we were very active in providing vaccine to, to, you know, to Central Virginia, to our footprint in Virginia, providing early on, as many or more vaccines to, to the health -- to people in our area, to our community, than the health system was able -- sorry, than the health department was able to do in fact. They were partners, but a lot of their ability to sort of step up was informed by, you know, the things that we did to address community vaccination. And as part of that we had, you know, significant efforts in not only the vaccine center that I told you about that was in Seminole Square shopping mall, but things like outreach vaccination efforts that went to nursing homes, or to people who were stuck at home, at home and doing a vaccine

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outreach, going to churches and providing vaccination. And as part of that, when we were first developing that plan -- I hope I'm not drowning on too much -- but we made sure to enlist what we felt were people that could speak to communities very well. So we engaged and found partners amongst our team members who were part of the Latino community, or part of the African American community and had connections, American-developed connections with, you know, black churches or with our Latinx community to do vaccine outreach. And these things echoed and were the things that we heard there. And we reflected that our health care providers, our team members are part of our community, and so those issues that we would hear about and knew we could hear about when we did this outreach would be reflected in our team members.

Q As part of that public health effort you were just referencing, did -- did UVA consider religious concerns?

A Well, the -- I think that they -- concerns, or religious out -- I mean, religious outreach.

Q Either one, I guess.

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A So I think they worked with our, you know -- "they" being, you know, some of the members of that community outreach team. It was not me. But they would work with the church leaders. And if there were questions about religious issues, I think they would -- and I'm speculating here, because I wasn't part of that conversation, but they would be addressed in that context. And it was, you know, outreach. It was providing vaccines. You know, it was -- we had this concept that, you know, vaccine hesitancy isn't really always hard and fast; that often you need to have conversations with people, education, understanding, having time for people to think about vaccination needs. Then come back and then have that conversation with them later, address more concerns, and then if you have that open dialogue, and especially if you have an open dialogue with a person that you have a relationship with, or maybe looks like you in terms of, you know, race and ethnicity, that those conversations can help lead people to, you know, a place where they'd be vaccinated, where previously, they wouldn't.

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We were very concerned about that, given the history that vaccination does break down along, you know, sort of vaccine acceptance, along socioeconomic factors. And that, you know, that in terms of equity, we had to, or certainly we desired significantly to address the issues of equity by doing outreach as much as we were able to -- as much as we could, and as thoughtfully as we could.

Q And that, what you're referring to was sort of a public health effort by UVA -- public health and education effort? Is that fair?

A Yes.

Q So when we go back to the question of employee and employee vaccination rates in say May of 2021, those public health efforts and information gleaned from that would have informed the UVA's discussion about implementing a mandatory policy, because they would have informed just the reasons why people in that community might not be vaccinated? Is that fair?

A I think it's -- it is fair to say that it would inform my understanding. It is not the only thing that occurred. So for example, the same process of informing, addressing questions, you know, giving a forum for people to understand where, you know, how to learn more about vaccination, this was a significant effort that started in December and continuing during this period of time. So, you know, town halls or meetings where I would come or somebody that, you know -- somebody else would come and be able to address questions from team members to ask about COVID, COVID vaccination, and you know, what else -- you know, it's not just, you know, vaccination, but, you know, other things. You know, what about travel? How do I keep myself, you know, healthy? Do I need to wipe down my groceries? All those types of things. Many, many forums to try to address those questions.

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Q Because the issues that the community needs in general are -- employees of UVA health are, you need the same information; is that fair?

A That's fair. Employees of UVA Health are reflective of our community.

MR. DIEHL: Can we go off the record for just one second?

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(Recess taken, 11:50 a.m. to 11:52 a.m.)

BY MR. DIEHL:

Q Thank you for that break.

We were talking about the employee vaccination rate, so -- and I believe, if I recall correctly, employee vaccination -- or let me start that question over.

If I recall correctly, you testified that team member vaccination rates were approximately 70 percent around beginning the of May 2021? Around that number?

A Seventy, 75 I think, yeah. I think that's a ballpark. And whether that was April, May, I'm not entirely certain.

Q And did UVA leadership believe at that time that that was about the maximum that would be -- that you would reach with just voluntary vaccination?

A I don't -- I can't speak for leadership, but I was concerned that we were reaching sort of a plateau.

Q And so the idea would be -- what -- what would be the goal of a number to reach in terms of

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vaccination percentage of employees or team members of UVA Health?

A Yeah. So not flippant, but I think that we would want to have everybody as vaccinated that would be able to be vaccinated, and, you know, didn't meet an exemption need. And the reason for that is that, I mean, it was evident that, you know, even at 70 percent, and I'm not quite certain where that threshold would be, that we were still seeing, you know, these cases of health care transmitted COVID that we were concerned were, you know, not proven, but very concerned to be from team members, and we were having operational issues around furloughed and sick team members who were not vaccinated, that that was leading to challenges to, you know, address just care of patients, you know, as we had waves of COVID. So, a specific number, that didn't have a specific number.

Q Was there any discussion about the issue of herd immunity, and what -- that a certain percentage would be good enough?

A Not that came up with -- excuse me -- pardon my frog in my throat. Not that came up in

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those leadership meetings. The concept of herd immunity became a very -- a concept that used to be just in epidemiologic circles prior to 2020, and then became commonplace and I think often misunderstood I guess in two thousand and -- you know, in 2021. But, I think there was sort of I think, I guess, a general gestalt saying that, you know, Once the virus has -- once we and the virus adapt to each other, then this would be -- we'll be past the pandemic. And I was often asked, When will we have -- and this is not from leadership, but this is just in general conversations. When will we be past this? When will -- when will this -- you know, when will we be done with this? And you know, I think it's pretty clear, that was a very difficult -- you know, it was difficult to predict. And often I, and I think many other people, were saying, This is going on longer than we were hoping and planning, but this is a worst case scenario, and you know, predicting the end is difficult, and maybe we're not going to know we're at the end until we look back.

Q So, why -- is it fair to say you

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characterized what you said about herd immunity, is that was sort of misplaced, or just not accurately discussed in the public discussion about COVID vaccination in 2021?

A Yeah.

Q What -- what was wrong about the general gestalt, as you put it?

A Well, you know, the first thing I think was, and I think that comes most to mind, is that, you know, once this virus affects everybody, they will have -- that the pandemic will be over, and it will be behind us. And, you know, the lack of recognition that that would cause so much morbidity and mortality that it would be, you know, a larger tragedy than already proved to be.

Q Was -- was there -- was it wrong because the virus was changing as well, and there were the different, different -- what were they called? Delta, the variants.

A The variant.

Q I couldn't come up with the word "variant." Sorry. Was that part of the reason why herd immunity

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was sort of a red herring for lack of a better term?

A That's a way to put it. I think there was a lack -- and I couns -- this came up in my talks often when I would try to teach on this, or talk about this, when you take a look at coronaviruses, there are four cold -- they're often called cold coronaviruses. You know, they're non-pandemic viruses, perhaps is another way to put them. And if you define "pandemic" as a virus that sort of changes the way that we live and interact with one another.

So those cold coronaviruses came into the human population at some point in the past. And it turns out, if you take a look genetically, in some of the cases, maybe not the too far distance past. Maybe a couple hundred years, maybe a thousand years or so. But at some point these viruses, which probably had an animal origin, I think, you know, the coronavirus experts are able to show that they likely had animal origins, at that same whatever event, spillover event, it got into human population so it could sustain transmission.

Now, those viruses are just cold viruses --

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"just." They, for the most part, unless you're immunocompromised, they don't cause problems. And there was anticipation, including amongst virologists and infectious disease experts, is that this would have that trajectory: Go from, you know, a pandemic virus causing huge morbidity and mortality to a common cold. I think what was not stated, and I think probably not -- we didn't emphasize enough, "we" being the scientific community, is to say, What does that trajectory look like, and how long does that take, and reflecting that that's an unknown. We had two other more recently spillover events with potentially pan -- you know, epidemic coronaviruses. That was SARS CoV-1 and MERS. And in both of those cases, those viruses caused even more mortality per case, you know, mortality rates of ten to 30 percent, that, um, we don't know what their trajectory would be if they were sustained in the human population to a point at which they became cold coronaviruses, or even, I guess theoretically, whether they would ever become cold coronaviruses, or would they be like -- I wouldn't wish this, you know, to see this experiment, but

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Ebola? What if they were like Ebola and never really lost virulence, or that we adapted to combat infection? So yeah, I think that that, you know, is a reflection that we didn't know what that trajectory could look like. And yes, as part of that, not appreciated at the time, was the development of variance. Because the variance could -- the virus could adapt to us the same way we could adapt to it. And that has been an experiment, a global experiment that has occurred over the last four years.

Q When you used the term "cold" in your last answer, are you referring to, like, the common cold?

A Yeah, common cold.

Q I didn't know if there was some sort of term of art about a cold virus as opposed to a hot virus.

A No. I'm sorry.

Q No, that's okay. I just wanted to clarify that.

A And I'll elaborate. So there are four -- there's four viruses. They go by different alphanumeric designations, like, gosh, HK-1. I'm

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forgetting the number, 30 -- you know, 33E4, or something like that, but these are, you know, viruses that cause the common cold. There are other causes of the common could, but these are some of them.

Q So there are viral causes of the common cold that ultimately aren't sort of that big of a public health event, any more at least.

A Correct.

Q And then the COVID, as we've been calling it, the SARS CoV-2 virus, is that sort of a more -- a slightly more technical version?

A That is -- that's a virologic name of the virus, SARS CoV-2.

Q And so that is different than those cold coronaviruses. It has different properties? Is that fair?

A It is a coronavirus. It's part of the coronavirus family, but it has different genetics, different structural makeup, and, of course, more disease.

Q More -- and more negative public health effects.

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A And it is a public health concern.

Q And then explain what you mean by variants and why the variants were a concern in relation to the herd immunity question we were talking about.

A Okay. Well, starting with --

Q And try to do it at a level that a civil midwestern lawyer could understand.

A I'll do my best. And I've had some practice, but I still don't know if I'm very good at it. But variants are simply descendents, or a family, but they are a version of the virus that has evolved from a progenitor or a, you know, a parental, a parent virus. And the way viruses evolve, and this is the way mostly, you know, in terms of the microbial world, how microbes evolve, is that they evolve often in relationship to immune pressure. In terms of other things, there's other ways things can evolve, like through the, you know, antibiotics or antivirals. In this case, there's going to be evolution in the context of that pressure.

So, a variant, so to talk briefly about coronaviruses, coronaviruses are named after crowns.

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And so the crown appearance that can be seen under a special kind of microscope called an electron microscope is the spike protein, which is decorating the surface of the virus. That spike protein has a couple properties. So the most importantly, it's one of the things that helps it attach to, to dock, to a receptor. It uses a specific recep -- human receptor called the ACE2 receptor that's displayed on epithelial tissue. So that's how the virus attaches to our cells. And the attachment is the first part of that virus, virus's process to get into the human cell. So you have to attach before you can invade so to speak.

A variant is -- so -- sorry. Take a step back.

That docking mechanism is so necessary for the virus, it's out there in the immunologic world, and our body develops antibodies to that, to that latch, to that spike protein. And there are particular parts of that protein, they call them epitopes, that are important for the function of that, of that spike protein. If you develop an antibody to

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that location, then you can block its interaction with the receptor that's located on that human cell.

So that's how one part of our immune system called antibody -- the antibody system, or humeral immunity, that's how, you know, we prevent developing -- or develop immunity to the COVID virus. We sort of, you know, develop antibodies that are interacting with that, with that latch.

Um, the way the virus gets around that is that if the virus has the opportunity to mutate, you know, through the selection process, through the evolution process, there will be mutations that develop in the protein, some of them -- actually the vast, vast majority of them are going to be disadvantageous to the virus, but a very small select some of them may be advantageous. And so they can mutate that protein, so it still functions, but the antibody no longer recognizes it. And so that is how evolution occurs, that's how the spike protein changes from one virus to another, and these variants are simply that virus, you know, a viral family, or a viral clone I should say -- not a family, but a clone,

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that's sort of developed and is more competitive, is able to overcome the innate immune -- not innate, but the immune system that's been developed in individuals. So that's --

Q So --

A Yeah. Go ahead.

Q Thank you. So when -- in 2021, we were talking about sort of the delta variant.

A Right.

Q That would be a mutation that was a different form of the virus? Is that fair?

A Yeah. And the delta actually had six or eight different mutations. As I recall, alpha, beta, gamma had their own different variations, but they developed these adaptations. And I'll also state that that was one of the surprising things about coronavirus, is that coronavirus as a virus family, they are built not to have mutations. They have proof, what we call proofreading polymerase. So they're built not to mutate very rapidly, in contrast to something like the HIV virus that is built to mutate. It is a mutator beyond comparison. And

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coronaviruses did not have that property, and so I think, at least from my perspective, I think for many, we were surprised at the ability of the virus to mutate so much that they would get around immune systems. But that, I think, is largely a reflection that there's so much virus in the world, because so many people are affected. So even though it had a proofreading polymerase, even though mutations were much, much, much, much less frequent than you'd see in something like HIV, they still had that, an opportunity to adapt and evolve in terms of their -- its ability to respond through human populations.

Q And individuals involved in public health would name those based on, what, Greek letters; is that right?

A That became one of the ways, yeah. There are multiple ways, but yes.

Q So what were the variants in 2021 that came through this area of Virginia?

A Well, you know, um --

Q And just, just looking for the names.

A In broad strokes, and just -- you know,

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I'll say alpha. I really don't -- so most viruses, it's not genetically sequent, so we don't know what the variants are that are coming through a population. Especially at that time, because there was not concerted efforts, there was not a catalog to do this. That sort of evolved through, you know, 2021, became more established 2022 and 2023. But alpha was the first one, so there's the original Wuhan strain. Alpha became sort of the dominant strain in winter 2020, 2021. I am not certain, and off the top of my head I'd have to go back and look at notes to see if there was these other beta and gamma. But delta became the variant that was seen predominantly here and, you know, nationwide, even worldwide, in the fall of 2021.

Q And then omicron came about kind of as the next big wave; is that fair?

A Yes. Omicron came about, emerged in South Africa. Whether that's where it was born or not so to speak, we don't know. But it first emerged Thanksgiving week in 2021, then caused pandemic worldwide disease by December, January, February 2021.

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Q So by December, January, omicron had reached Charlottesville?

A Yes.

MR. DIEHL: All right. So let's go off -- take a break.

MS. McGRAW: Lunch break?

MR. DIEHL: Yeah.

MS. McGRAW: Okay.

(Lunch recess taken, 12:09 p.m. to 1:28 p.m.)

BY MR. DIEHL:

Q All right. Back on the record. Dr. Sifri, you understand that even though we've taken a lunch break, you're still under oath today?

A I understand.

Q And you understand that you're still testifying, and your testimony today is on behalf of the University of Virginia as a spokesperson, and not -- we're not deposing you in your individual capacity today. Do you understand?

A Yes, I understand that.

Q I want to walk through Exhibit 21, the binder, that you have there. Can you just describe the, the different documents that are included in there? And I might ask you some question, but just to get a description of them in the record.

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A Sure. The first, of course, is a table of contents. After that are several versions of the vaccine policy, OCH-002 for the health system. And then after that are then a list of Email correspondences and notifications regarding the evolution, I guess, of the vaccine policy. And the final thing I forgot to mention was a list of the various COVID policies and protocols for the health system that were produced.

Q There is a document that I believe is the last document in there that -- I'm just finding my copy of it -- that has a bunch of sort of small print on it I guess, for lack of a better term. And it doesn't have Bates labels. Do you have that document?

A Yes.

Q And what tab is that in the binder?

A F.

Q What? Sorry.

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A It's tab F.

Q Okay. Sorry, I didn't hear that.

A Or tab C?

MS. McGRAW: C. There's an extra -- looks like there's a --

A Yeah, it's tab C.

BY MR. DIEHL:

Q Okay. And there is -- there is a list, it looks like a print off of file names. Is that -- is that an accurate description of the document?

A Yes.

Q And what are all these different files?

A These were produced, I think with counsel's help, or recommendations, I don't know how they were collated, but these are a list of the different protocols, I think I just mentioned this, the protocols and practices that the health system employed during the COVID pandemic, regarding COVID specific work. And they include everything from -- and I can just go through this --

Q I don't need you to go through it obviously, because I can read it.

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A Okay.
Q But the -- well, I guess, it starts with number 65 and 95, and then that title continues? Do you see that?
A Yes.
Q And then if you go to the last page, it ends with Workspace Safety? Is that correct?
A Yes, that's correct.
Q And then on the right side of the document, there are some dates printed next to each file name. Do you see that?
A I see that.
Q What -- what does that date represent?
A Um, my understanding, since I didn't produce this, is that that was the date that that document was either created or at least saved in its last version. I haven't gone through this in detail to look at it, but just in reviewing it, it seems that in general a document that, for example, I'll reference WCH, Inpatient COVID Action Plan Version 12 is dated from the person who produced it, September 24, 2024, and that does seem to line up with

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when the -- that date is shown in the right-hand column.
Q And there's no page numbers either on this, but if you go to, say for example the -- well, just go to the last page of the document. There is a box that's checked next to Visitor Restrictions Policy Limited Final, 01.03.2023 dot zip?
A Uh-huh.
Q Do you see that? Yes?
A I do see that.
Q And above that there's a title that's -- it's not legible. Do you see that?
A I see that as well.
Q Do you know if that is the -- well, it looks like if we go to the page before, there's a checkbox next to Visitor Restrictions Policy Limited Final, 01.03.2023.docX?
A I see that.
Q And do you think that that is the cut-off title so that we've got -- I guess, put it this way: Are all the cut-off titles captured on the nex -- the previous or next page?

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A I will say, because I'm not entirely certain. I don't know if I can speak exactly to that, but the one that you referenced, the file below that, Visitor Restriction Policy Limited Final, 01.03 2023.zip, Z-I-P, it appears to me that on the subsequent page that maybe the very bottom part of that line cut off. So if that's what you're referencing, I agree with -- I think that that's accurate. Although, I think you referenced the line above it.
Q Well, let me ask you this: Do you know where these files -- well, this document shows file names, but these are real files stored somewhere, correct?
A Um, I -- uh, yes.
Q Do you know that, or are you guessing?
A I'm guessing. I don't know that for every single file.
MR. DIEHL: Wendy, this is the one time I'll encourage to speak. Just joking.
MS. McGRAW: Okay. I was wondering.
MR. DIEHL: But it would probably be easier

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if you could tell me what this is, and --
MS. McGRAW: Yeah. So you had a very broad topic on your deposition notice that I think was, Everything you did to protect against COVID from 2020 to the present. In an effort to provide you and the witness with something to talk about with respect to such a broad topic, we -- there was -- there's someone, her name is Christine Hall, I believe, --
THE WITNESS: Uh-huh.
MS. McGRAW: -- who keeps a file of all of the policies and guidance that I believe actually got posted to an intranet site. And we just did screen shots of what she had in the files. The files do exist, it's there.
MR. DIEHL: Okay.
MS. McGRAW: But these are just screen shots. And to the extent there's like -- you said it looks like there was a -- you weren't sure if everything was captured, the idea was to screen shot everything. And that probably, because it's not -- screen shotting is not really that user friendly, --
MR. DIEHL: Okay.

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MS. McGRAW: -- that's probably why there's some overlap. But if you -- if there's particular policies that you want to see, I don't know that any of them are within the scope of your request for production, but I'd be happy to talk with you about it.

MR. DIEHL: Sure. And we'll deal with that later.

BY MR. DIEHL:

Q What was the name of the woman that we just talked about, Dr. Sifri?

A Christine Hall.

Q And -- and what's Ms. Hall's role, to your knowledge, with UVA?

A That her -- she is one of the individuals, I think the lead individual, there's only two that come to mind, that deals with hospital policies and to make sure that hospital policies are -- you know, she sort of makes sure that they're up-to-date, that they're meeting all requirements, are reviewed on an appropriate cycle, et cetera.

Q And so any of these policies re -- well,

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and it's your understanding these policies relate to different versions of policies related to COVID safety or precautions related to COVID? Is that fair?

A I'll revise that. I think that they are all to do with COVID. I understand now that they were obtained by Christine from policies that were uploaded to this working web page that we have regarding COVID care in the health system. I'll just say that policies have very specific connotations in health care. Some of these are protocols or practices. They're not all policies. Policies do have sort of the weight -- it's not -- I guess we're not -- it's not -- and I know that we're in a deposition, but certainly not legal muster. But when we follow a policy, we have expectation that the team members will follow it. The protocols and best practices and flowcharts and things like that sometimes are working documents to help our health care providers, team members and employees to work through the process of providing care.

Q So fair to say these might be everything ranging from suggestions or best practices all the way

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to mandatory policies; is that fair?

A Yeah. So, yeah. So the range of, as examples, a policy is regarding PPE and universal masking is a good example of a policy. And a Pfizer COVID-19 vaccine comparison table would be an example of a product that's used for team members to be able to speak either perhaps to patients, or to themselves regarding that. Or a parking FAQ would be sort of frequently asked questions regarding parking.

Q Right. Okay. So just set that aside for now.

The -- we were talking before lunch about changes to the vaccination policy, policy OCH-002. And, um, the -- I wanted to ask about, um -- well, we were talking about when that policy changed to reference the COVID vaccine. Do you recall that testimony?

A I do recall that testimony.

Q And the first time that policy was changed was in July with respect to a change related to new employees? Is that correct?

And I should say -- and I should maybe ask

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a more careful question. I'll start over.

The first time that policy was changed to reference the COVID vaccine was in July of 2021, related to new employees, but not existing employees of UVA Health. Is that correct?

A I'm going to be accurate, so I want to just double-check. But July 1st -- that's the wrong one. July 1st, 2021? Yes. Yes.

Q And you're referring to a document in there. What's the Bates number for that document?

A The Bates number is 435.

Q Okay. And it's UVA 435?

A UVA 435.

Q Thanks. Okay. And so that, that policy was changed to reference new employees. When did -- when was changing the policy to reference -- let me start that over.

When was that policy changed to reference current employees being required to receive the COVID vaccine?

A That is -- I'm referencing also document September 1st, 2021.

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Q And what Bates number are you referring to there?
A UVA 457.
Q When was the -- that change between those two documents -- and do those have different tabs in your binder?
A Yes.
Q What is the July policy change tab?
A The July policy change is tab, Tab 4.
Q And then -- and then is Tab 5 the August -- or when was the next change?
A Or, you know what? This is interesting. Yeah, I didn't recognize that before.
Um, the September 1st, is that the question?
Q Yeah. When was the next policy change?
A The next policy change was Tab 5 on September 1st, 2021.
Q And that September 1st change, was that the change that was announced, I believe, on August 25th about adding current employees require -- or excuse me, yeah, adding current employees to that mandatory

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COVID vaccination policy?
A Yes.
Q And that change between the policy in Tab 4 and the policy in Tab 5, when did UVA begin to think about making that change to the policy?
A Um, I guess UVA, sort of thinking of the leadership structure, I think probably August, early August or late July, in that time frame. It was, you know -- yeah.
Q Was --
A In that time frame.
Q When UVA first -- when any leaders at UVA started talking about mandating the COVID vaccine for any employees, new or existing, that started in late April and -- or early May? Is that right?
A Correct. I -- that's what I said, because that's when I first recall having those conversations.
Q And given the decision-making structure, and your role in that, you personally would have been involved in leadership decisions related to COVID vaccination policy changes from at least very early in the process; is that fair?

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A I think that's fair.
Q And isn't it true that in -- I'm just going to -- I'm just going to use May.
A Yes.
Q Let's just assume those are being discussed in May? Is that fair?
A I think that's fair.
Q That change to the policy?
So with respect to that change to the policy being discussed in May, isn't it fair that mandating vaccination for all UVA Health team members was discussed beginning in May? Is that fair?
A Yes, because I was involved in that, and so that was one of the discussion points, yeah.
Q What -- so if that was discussed at the outset, why did the first policy change happen, and not sort of all -- both policy changes happen at the same time?
A I don't know. I think there were views of different options available. They included what occurred in July, which was, you know, requiring it for new hires as, you know, a way to start this

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process with team members where you could collect that information at the time of their hiring, what they call onboarding, versus doing it for everybody at that period of time. As I said, that was something that some health care institutions had done, but at least in May was, I don't think, um, a common practice. It was done by a notable few.
And then, you know, I wasn't in part -- in the decision-making process at that time to say, What are the benefits and challenges of doing it -- you know, to doing it for everybody starting in July, or should we just do it for the people coming onboard?
Q And was there an estimate of how long it would take to increase the vaccination rate in a significant way among team members just by mandating vaccination for new employees?
A No, I didn't see an estimation of time. Although, I will say that there was, at that time, still considered effort and interest to ask managers and to put out information from -- in the information channels I talked about earlier with, you know, leadership -- well, not leadership, with town halls

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and other written communications and online communications to encourage vaccination. So there were efforts around that to improve vaccination above that sort of mid-70 percent rate that we talked about in May, and see how far and how robust that could be -- or not robust, but how effective that could be without a requirement.

Q And as that first policy change in July was implemented, did UVA gather enough information to decide on the second policy change, or was it just -- well, just answer -- ask that -- let me ask that question again, or make it more clear.

A Yeah.

Q As the first policy change was implemented on July 1st, and then September 1st was the next policy change to expand that to existing employees, was that based on information gleaned from the additional vaccination rate from the new employees that were being added to work for UVA Health?

A Um, I think it -- I think -- my recollection is that at that time, there was -- it was more of an appreciation that there were the challenges

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with ongoing exposures, and team members being furloughed, and short-staffing challenges that were occurring as COVID, you know, affected team members, and that the work through required vaccination of new team members coming onboard and through encouraged vaccination of current employees was, while maybe that was having some benefit in reducing the number of unvaccinated employees, was not sufficient to mitigate that, those exposures and those lost health care workers.

Q And is it -- was there data that UVA was collecting with respect to, you know, the number of days, or approximate, at any given time, the number of employees that were absent due to COVID exposure or having COVID themselves?

A There was an ongoing report that was available to the leadership on that, yeah. A number of -- yeah. I'm sorry.

Q And -- go ahead.

A As I recall, it was the number of infected and furloughed health care workers, and delineated by role, sort of broad stroke: Nurses, physicians.

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Q And was there an estimate of how much vaccination would change those absences?

A There was not. Yeah, nobody asked me, for example, At what point do you think that, sorry, gap is closed, or you know --

Q And you believe that you would have been involved in, personally, in discussions related to the effectiveness of that policy change or, you know, monitoring that data? Is that fair?

A I think I could have been asked. There's others that may have been asked, people that, like in Employee Health, Work Med, sort of the Occupational Health Services, or administrators over those areas may have been asked about that. And they may have had more information than I had. But I -- I also agree, I think that I -- there's a probability that I would have been asked about that.

Q In any event, when you were preparing to testify regarding policy changes and the reasons for policy changes to OCH-002, that didn't come up. Fair?

MS. McGRAW: Object to the form.

A Yeah, I don't recall that coming up, yeah.

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BY MR. DIEHL:

Q And by "that," we mean -- we're referring to how much the vaccination -- the addition of mandatory vaccination would change the number or length of employee absences. Is that what you understood?

A That was one of the consider -- I think -- just to make sure I'm right, rephrase the question? Or restate the question?

Q Sure. Well, let me just ask it again just so we're clear. As UVA was thinking about the policy change that was reflected in the July 1st changes to the policy or the September 1st changes to the policy, I understand your testimony to be that an impetus for both of those changes was to reduce the number of absences or the length of absences of employees due to COVID exposure or contracting COVID. Is that fair?

A I think that's fair with the -- if you would allow me to expand.

Q Sure.

A In my seat as a hospital epidemiologist is one of those considerations. The other consideration

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was concerns for transmission of COVID within the hospital from health care provider to health care provider or the patients. I just wanted to make sure that that was clear, that was not the only consideration.

Q Yes. Understood. I might come back to that. But I was just sort of asking about that one concern. Whether there were others, there may have been others. Fair?

A Fair.

Q Okay. So with respect to that concern, did -- the concern -- well, and just so I don't have to repeat it and everything's clear, I'm just going to talk about employee absences, just -- or how about if I say COVID-related absences? Does that make sense? So by "COVID-related absences," I mean employees who are absent because of contracting COVID, or because of being exposed to COVID. Do you understand that? Does that make sense?

A Yes.

Q Okay. So as those policy changes were being considered, was there any data available to UVA

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decision-makers that -- regarding whether those changes in July -- the changes announced to the policy in July or September would change the frequency or amount of employee COVID-related absences?

A Um, I think it's fair to say that there was certainly hope that they would change those employee-related absences. And um, I think it's important to note that, you know, it's just not in that state of absenteeism that was the concern. It was that operations in a specific area may be compromised when you have an exposure or group of infections that occur amongst a small group of health care providers. And there were examples of that as I recall. And some of them were large that occurred, you know, before, you know, this time period, but you know, I'll give one example. So, on Halloween 2020, we had a pediatric patient who was run over by a family member during Halloween, who developed COVID, was not tested for COVID -- or actually, I think they were tested for COVID, and this person was, was sort of likely incubating COVID, so not testing positive at, on admission, but then later manifested COVID.

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And this person, child, was critically ill, and the team did a lot of effort to try to -- and I can't remember the outcome, if the child survived or not, but was critically ill, was intubated and extubated, so put on a breathing machine, taken off the breathing machine, put back on the breathing machine. And the child had COVID when this occurred, and exposed a large fraction. And again, this is an estimate, but as half or more of the ICU. And I'll just finish really quickly. And that led to moral angst and challenges in that, that we were -- we had to keep the PICU open with those health care providers who were exposed to COVID, and they were very scared of transmitting COVID, should they develop it, to other vulnerable patients. So that was an extreme example, but that was sort of the milieu that, you know, we had that experience with.

Q And that -- and that, October of 2020 was before employees were vaccinated, correct?

A That is before the vaccine was available, yeah.

Q Okay. So -- so with respect to the policy

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change -- and the policy change that we're talking about related to mandating vaccination for new employees or current UVA Health employees or team members, correct?

A Correct.

Q So was there any data specific to vaccination and any change in, in employee absences related to COVID?

MS. McGRAW: Object to the form, data vague and ambiguous.

BY MR. DIEHL:

Q You know what I mean by "data," don't you?

A I do.

Q So was -- did UVA Health have any data specific to the issue of the impact that a vaccination mandate might have on employee absences related to COVID at the time the decisions were made to change the COVID vaccination policy in July or September of 2021?

A So, I understand the word "data," and, um, so we did have collated, rolled-up data that speaks exactly to that. What we did have experience with

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would be a manager that have exposures amongst a group of their team members, and then have operational challenges in staffing their clinical operations. And so I don't -- those were not -- those anecdotes were not collected, but that was a very common experience during this period of time.

Q With respect to any of those anecdotes, would those have been anecdotes from, say for example the summer of 2021?

A Yes.

Q So, um, did UVA look at those anecdotes and determine whether the spread of COVID was due to an unvaccinated employee as opposed to the 70 percent or more of employees who were vaccinated at that point?

A No, I don't think that that -- that was not done. At that period of time, we were so busy that trying to do -- contact tracing is what you're describing. To do contact tracing to the point of being able to understand origins of infection, that was not possible. We could do exposure tracing to understand if team members needed to be furloughed. But to understand sources of infections, those were

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challenging.

Q Was there any way that UVA Health leaders knew that the change related to mandating vaccination would have some positive effect based on any, any actual data or actual information from its own or from external sources?

A Um, so we're talking -- you're asking specifically not furloughs since exposures, but rather reduced infections?

Q Well, I'm asking about -- you explained that there were COV -- absences related to COVID, and those absences could have been related to an exposure, and those absences could also be related to the employee contracting COVID, fair?

A Yes.

Q And so with respect to those absences, was there any specific information that UVA had or that it relied on to determine that the change in the vaccination policy in July -- let's just start with July of 2021, --

A Uh-huh.

Q -- that that change would have a positive

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impact on employee absences related to COVID?

A I think -- so -- I keep saying "I think." I will answer yes, in that we knew vaccinations, "we," what was reported from Employee Health and Work Med, vaccination rates across health care provider groups was being reported. There was an understanding of when those absenteeisms occurred as a consequence of exposure. So again, if you were not vaccinated and you had an exposure, you didn't wear a mask, you didn't wear eye protection, you were around somebody that was COVID positive as a health care provider, those patients were furloughed -- sorry, those health care providers, those team members, were furloughed. And so there was the data regarding, you know, absenteeism, or it's actually furlough. There's the information regarding who was sick versus who had -- who were off of work because of exposures. And then there was, again, the anecdotal information of units that were affected. And so putting those together, there would be, at times, an understanding that -- and I don't know these exact numbers at the time, and I think they change, but if there was ten or 15 percent

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of let's say a specific group of nurses were not vaccinated, and, um, that 20 nurses were out because of infection or because of exposure, I think there would be an understanding that a way to have reduced that would have been better vaccination in that, in that population of health care providers.

Q Well, I guess I'm not asking you to guess or speculate. I'm asking about actual information, actual data or studies that, that were relied on by UVA in making that determination.

A Studies were challenging at the time, because they're -- we are overwhelmed with studies. But the data that I just described, without specifics, was examples of the data that were being obtained, you know, I think to hospital leaders on a routine basis, on a daily basis. They would have the report from the dashboard, a number of employees that were off of work because of infection or because of exposure, and they would have the information regarding vaccination rates in that specific population.

Q Well, but was the data broken down by the absences, and then which of those employees that were

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absent were unvaccinated versus which were vaccinated?
A No, I don't -- I think that was privileged information, so it was population level. Because at least that's the data that I saw, sort of, This is the number of team members that are vaccinated amongst nurses, amongst support staff, amongst physicians, and this is the number of absences. There may have been, like, examples of that, like when they would -- when, you know, Employee Health did a workup, taking a look at a specific group. I didn't see that reported routinely.
Q Well, were employees required to report their vaccination status in the summer of 2021?
A Um, were they required? I believe that they were at least strongly encouraged, if not required. We had that data, and I know that Employee Health and the data analytics group worked very hard to try to understand that information. Vaccination, vaccines were being reported to the state through an electronic server, and I think my understanding is that data was then used to feed health care provider vaccination rates across the team members. And of

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course, internally, there was an idea that the health care providers that UVA vaccinated through work -- through our Employee Health services, those -- that data was captured.
Q But it's my understanding -- well, I want to understand your testimony. Did UVA then take what information it had on employee vaccination and correlate that with, you know, these ten employees are absent. How many of these are vaccinated versus how many were not vaccinated? Was that level of detail available to UVA in the summer of 2021?
A That required -- it sounds like a simple question, but I believe that that required a substantial amount of data mining. So I think there were examples that was -- that that analysis was performed, but I don't recall that occurring, like, on a running basis, like on a dashboard.
Q Well, examples, do you mean individual anecdotes, or do you mean a representative sample set?
A Um, I'm not exactly sure what you mean by examples, but I guess it was examples. It was like -- it would be like there's, you know -- there's 20

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nurses that are out -- and again, I don't want to pick on nurses, but it's as examples.
Q Sure.
A But there are 20 nurses that are out. How many were -- you know, why are they out? Is it because of infection, or is it because of exposure? How many were -- you know, what percentage of those were vaccinated? I recall there being examples of that, yes.
Q So I'm just trying to understand what you mean by "examples." I'm not trying to use the word "examples." So do you mean that UVA did that routinely for all employees that were absent due to COVID? And by do that, I mean, analyzed whether the employees were absent due to COVID and were unvaccinated, or due to absent -- excuse me, or were absent due to COVID and were vaccinated? Do you know if that analysis was done for employee absences across the board at UVA in the summer of 2021?
A Not through the summer of 2021. So when it's examples, it's exactly as I said, examples. Because the individuals that were doing that work were

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doing the other things like taking care of patients, or taking care of employees that were sick. So it would be asked of leadership to do that analysis, and I think it would occur in that context, but it was not routinely reported on an ongoing basis.
Q And you were aware of employees at UVA Health in the summer of 2021 who were absent due to COVID and who were vaccinated, correct?
A Correct.
Q Did you have any analysis available to show the relative length of absences for employees related to COVID that were vaccinated versus the length of absences for employees who were absent related to COVID, but were vaccinated?
A Not an analysis, but we could say that what we would do is that a person that was not vaccinated and was exposed were furloughed. They weren't working. If you were exposed and vaccinated -- if a health care worker was exposed and vaccinated and not symptomatic, they were allowed to continue to work per hospital policy which followed CDC guidance.
Q And so that was a policy choice by, by UVA,

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correct?
MS. McGRAW: Object to the form.
BY MR. DIEHL:
Q By that, I mean, the length of furloughs or whether to furlough an employee due to exposure, UVA chose to apply one policy with respect to vaccinated employees, and one furlough policy with respect to unvaccinated employees, correct?
A As much as possible. And in fact, almost in -- I can rarely think of any differences. We followed CDC guidance. And so CDC guidance, while not policy, we would use as the basis of our policy.
And while you said earlier that guidance is guidance, it's not a policy, government doesn't set that, if the health department were to come to UVA and ask about our protocols, procedures, and practices, they would use CDC guidance as their understanding of what we should be doing. So we've always used CDC for better -- for our North Star in terms of our policies and practices, and kept them aligned as much as possible with their guidance.
Q But I guess, did you know that that

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guidance was warranted based on data?
MS. McGRAW: Object to the form.
A Um, yes.
BY MR. DIEHL:
Q What --
A So the CDC guidance is, with our experience, my experience as being a hospital epidemiologist for 15 years, is data driven. It's based on review of the evidence at hand at the time. And based on that, we feel -- I still feel very comfortable knowing that it's an understanding that, you know, evidence can change. Things can change. But at the time, evidence -- the evidence was such that that would support those protocols and practices.
I'll give an example to show maybe where things are lockstep, but we need to -- that we follow guidance.
Q Well, that's the thing, I don't -- I don't want you to just give me examples about guidance. I'm talking -- I'm asking a question specific about data on which you relied.
A So I'll give an example.

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Q So with respect to data in July -- or not July, but in the summer of 2021, what data are you referring to that indicated that the, the UVA policy or CDC guidance that drove that policy was correct with respect to the length of absences for unvaccinated versus vaccinated employee furloughs?
MS. McGRAW: And I'm going to note an objection, because you cut the witness off. Go ahead.
MR. DIEHL: Well, I just -- it seemed like an unresponsive answer.
BY MR. DIEHL:
Q So if you understand the question, I didn't mean to cut you off. I just meant that's the question I'm asking, to make sure you answer that.
A Okay. And I'm sorry if it was an unresponsive answer.
Q No, that's not an insult. It's just --
A No. And not as an insult. I think it's an incorrect question. So there's -- you're saying there's a difference in length of absence, but there's actually -- I mean, it's an infinity difference between length of the absence. So if you're

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vaccinated and exposed and don't have symptoms, you are not furloughed. You don't remove from work, so that's zero, whereas if you are not vaccinated and you were exposed, then you have had a ten, and then seven-day furlough at the time. So that evolved over time. So what is the --
Q To clarify, I guess -- yeah.
A So what is --
Q I think you're -- sorry. I don't mean to interrupt. I just want to -- I assumed that for my question, --
A Yeah.
Q -- just to make that clear, that there was a difference in the furlough.
A Right.
Q Or there was no furlough, and there was a furlough.
A Yes.
Q But what data drove that decision to have a difference in furlough length?
A Okay. And -- yeah. So, um, understanding that the COVID vaccination -- that the COVID vaccine

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is protective, and that individuals can be asymptomatic, develop infection, can be presymptomatic and shed virus before developing symptoms, and that we cannot test health care providers on a daily basis. And then finally, because COVID is a safe and effective vaccine that was protective from infection, that if you were unvaccinated, you were more likely to develop infection for a given exposure that, therefore, um, a furlough was indicated, or furlough was justified for a person that did not have COVID vaccination, did not have the protection of preexisting immunity to COVID as best we -- compared to an individual that was vaccinated. So that, that are -- those are the data. Did the CDC provide --

Q The --

A Oh.

MS. McGRAW: You've got to stop cutting him off.

MR. DIEHL: Well, I need to ask my questions and get done today, so -- and I'm trying to understand -- I'm trying to ask a question about something he just talked about that I'm gonna, you

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know, need to get back to.

THE WITNESS: Okay.

BY MR. DIEHL:

Q I'm not trying to cut you off, other than ask for clarification. You know, with respect to the vaccine being safe and effective, and what -- well, was there specific data related to the risk of transmission after an exposure between the two different populations of employees, vaccinated and unvaccinated?

A Um, we -- um, between employees? So, um, yeah. So I think you're ask -- if you're asking about the risk of forward transmission of somebody that is vaccinated versus unvaccinated, --

Q Yes.

A -- that has been a topic of, of considerable interest since the, since the vaccine. And I'm trying not to be pedantic about this, but talking about September of -- or summer 2021, that information was still in evolution. There were thoughts, but I don't think that there was strong evidence at that time for a significant reduction in

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forward -- there -- it was proven that forward transmission was significantly reduced in people who were vaccinated versus unvaccinated. However, I think by 2022, those data came into more clear focus that indeed, if you were vaccinated, you were less likely to forward transmit COVID through studies that involved not the health care setting, but household contacts, and if I remember right, the prison setting. But, you know, extrapolating from those, that -- the data -- the data supported those.

Q So in July 2020, for example, you were aware that professional athletes had contracted COVID even though they were fully vaccinated; is that correct?

A Uh-huh. That is correct.

Q And you're aware that at that time, that fully vaccinated people could spread COVID even though they're fully vaccinated, correct?

A That is correct.

Q There was some -- if I -- is there -- was there -- do you recall a study that was published -- I don't know if it was a study, or some information

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related to an outbreak in Massachusetts among a population that was fully vaccinated, that were very -- everyone was surprised that COVID spread among that group. Do you recall what I'm referring to?

A Yeah. So I presume you're going to be talking about, it was the Barntstable outbreak in amongst mostly gay men in Provincetown, I think is what you're probably alluding to.

Q Yeah. What -- what was the data that came out of that, that, I guess, outbreak?

A Yeah. So, there was a highly vaccinated, in fact, if I remember right, maybe vaccination was required for going to that event. I may be incorrect about that. But it was a very highly vaccinated population of men in Massachusetts, and that there were cases, in fact about a hundred or so cases if I remember right, of COVID that occurred. I can't remember what the number of men that were there, but a number of cases of COVID in these men that were fully vaccinated.

So, the report that you're referring to, if I remember right, was an MMWR. And the reason I

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remember that is because, and unfortunately, in my opinion, and reflected in some of my talks, was -- you know, was the paper or the report that labeled them as breakthrough infections, which is not the right term that most of us -- well, not most of us, but many of us in our field feel is not -- it's sort of a pejorative term. It really should have been infection after vaccination.

Q So the term breakthrough, as if it was somehow different, is not accurate. I guess, what's wrong with the term breakthrough, just without getting us off track, but just to understand what your comment was.

A Yeah, from my understanding, breakthrough connotates failure of the vaccine. And there's no vaccine, maybe short of maybe rabies vaccine, but even that, where infections can't occur after vaccination. So certainly see that with the flu. I've seen that, in my knowledge, one time with rabies. So rabies is pretty darn close to a hundred percent. And then most other vaccines are, you know, in the middle.

Q So fair to say that in the summer of 2021,

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UVA Health was aware that vaccinated individuals could contract COVID and could transmit COVID to others. Fair?

A Fair.

Q And in the summer of 2021, unvaccinated employees of COV -- of -- let me start over. Of COVID? I don't know. I'm using too many, too many terms here.

Starting over. In the summer of 2021, UVA Health was aware, or -- see, now I'm going to object to my own question again, and I just need a sip.

In the summer of 2021, UVA Health was requiring unvaccinated team members to test on a weekly basis, correct?

A Correct.

Q And how did UVA Health determine the relative risk of transmission between employees who were vaccinated and employees who were unvaccinated, but were testing on a weekly basis?

A I am -- it was my determination, and I know I'm speaking now within in the context of the health system, so the health system's anticipation would be

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individuals that were not vaccinated represented a greater risk for developing COVID infection, and a concern that they also could, therefore, be an increased risk for asymptomatic infection and for transmission of the virus. And that testing was unclear if it would be, um, to be able to fully close the gap between the risk of the vaccinated and unvaccinated, but it was a tool at hand to reduce that risk. And so the concept of, again, multilayered approaches to risk reduction.

Q So in the summer of 2021, UVA did not have data that indicated a difference in the risk of transmission between unvaccinated individuals who were not -- or who -- excuse me. Let me start that over. Sorry. I'm just --

So we're talking about the difference in risk of transmission between unvaccinated individuals who are engaging in weekly testing for COVID, as compared to vaccinated individuals who did not engage in weekly testing, and with respect to the relative risk of transmission between those two groups. Do you understand that?

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A I understand that.

Q So in the summer of 2021, there was not data that UVA Health had regarding the relative risk of transmission of COVID between those two populations; is that fair?

MS. McGRAW: Object to the form, asked and answered.

A Yeah. So in the middle of the pandemic, we were not -- did not have that information at hand, and wouldn't have that ability to do that relative risk comparison.

BY MR. DIEHL:

Q And did you consider that risk and consider that individuals who were unvaccinated, but were testing, the testing did lower the risk of transmission, or at least likely would? Is that a fair assumption?

A Um, it was certainly a hope that it would reduce the risk. So, that was certainly a hope. Did we think it absolutely did? No. But we were certainly hopeful, and that's why we did it.

Q Did that hope turn out to be wrong?

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A I think we identified individuals that had COVID, so I think that, um, inasmuch as those individuals who had asymptomatic COVID were in the health care environment, that did pose risk. So I think it did close some gap. It did reduce some risk, yes.

Q Did UVA Health, at some point, determine that data indicated some comparable difference in the risk of transmission between unvaccinated individuals who tested on a weekly basis versus vaccinated individuals?

A No. I think that would have been so epidemiologically challenging to collect that data and to do that comparison, and at the same time, we were trying to keep the other processes. And so we weren't able to do that. And I actually think that -- I think it's a very difficult study to do, because I think it's informed by the relative risk of infection at the start, right? So if you're doing a lot of weekly testing, and there's very little COVID in the community, then you're expending a lot of resources, and perhaps the risk is not that large. But if

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there's a lot of COVID in the community, then that calculation changes.

Q Do you know of anyone that has studied that at any point after the summer of 2021, to make a determination with respect to the relative risk of transmission between unvaccinated individuals who are testing on a weekly basis versus vaccinated individuals who are not testing on a weekly basis?

A I'm not aware -- not to say that there may be, but I'm not aware of setting -- of that type of testing in hospitals or health care systems. I believe there was some analysis. I don't know if it was exactly to what you speak, are speaking of, but in terms of testing of college students trying to do that calculation. But that very well may have been before broad use of vaccines in colleges, but when they were doing -- you know, testing their college campuses.

Q It would be possible to control for the different variables you were referencing and obtain some data with respect to the relative risk between those two populations; is that fair?

MS. McGRAW: Objection, beyond the scope, calls for speculation. You can answer.

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A I think it's certainly -- I think it would be possible, yes, to do that relative risk calculation with enough resources and enough testing, yes.

BY MR. DIEHL:

Q But UVA did not undertake that analysis, correct?

A I don't think that we would have been able to do that analysis even with the personnel on hand with the testing -- type of testing protocols that would be needed to do, to do that analysis.

Q That wouldn't have been possible at any point from the summer of 2021 to the present?

A No, yeah. No, yeah. Sorry. It would not be possible. I think you'd have to have more testing to be able to answer that, that question.

Q After -- at some point, there was decisions made with respect to exemptions for either religious or medical reasons. You're aware of that, correct?

A I am.

Q And what measures were required for individuals that returned to work and were not, were

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granted exemptions for either medical or religious reasons? What cautions were required of those individuals when they returned to work? And I'm talking about that time period of the fall of 2021.

A They were required to undergo weekly testing, and they were required to wear a mask in, at work, unless they were, like, alone and closed doors in their office. And there was a timing that at one point where universal -- we call that universal masking, where universal masking was not being practiced in the health system. But right around that time, and I frankly can't remember exactly if it was, you know, the month, but universal masking became standard for everybody in the health system, so -- but it was in or around that time, around the omicron surge, or maybe the end of the delta surge.

Q I'm sorry. What happened around the end of the delta surge and beginning of the omicron surge?

A That health care providers wore masks, you know, in the health care setting when seeing patients and, you know, in hallways, et cetera.

Q Well, masks were required before that time

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period, correct? In the pandemic?
A They were. They were. There was a period of time in the spring of 2021 where if you were vaccinated, masking was not required. Or at least not -- you -- health systems could elect not to -- or, yeah. That's -- health systems could -- were advised that universal masking was no longer needed.
Q Were some of the initial assumptions related to the effect of the vaccination on reducing the risk of transmission, were some of those initial assumptions wrong?
MS. McGRAW: Object to the form. Beyond the scope as well. Go ahead.
A Yeah. Yeah. When you say the assumptions, that's a pretty broad question. The assumptions could go both ways. It could have a total benefit. It would be completely irrelevant. What are you exactly asking?
BY MR. DIEHL:
Q Well, there were assumptions when the vaccines came out that -- regarding their effect on a vaccinated individual's risk of transmitting COVID.

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Fair?
A Yes.
Q And those assumptions would have affected UVA's policy making with respect to vaccination.
Fair?
A Correct.
Q And so some of those -- whatever those initial assumptions were about the reducing the risk of transmission when an individual's vaccinated, was the initial assumptions regarding reducing transmission, were some of those initial assumptions overly optimistic?
MS. McGRAW: Same objection. Object to the form, beyond the scope.
A So there were some that assumed that COVID vaccine and the vaccinated individuals would not only have very, very high levels of protection from severe infection and death, that not only would they have that protection, but also protection from mild infection and also very, very significant protection from transmission, right?

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BY MR. DIEHL:
Q Those are the -- not to interrupt you, but those are the initial assumptions you're referring to?
A Those are some individual assumptions. Again, I think that in others -- in -- amongst some experts, I think that those were -- and I would include myself in those -- those were unknowns, and we really did effort, when we were counseling about this, to talk about the difference between sterilizing immunity and just reduced infection. And understanding that sterilizing immunity, which I guess I should've defined, but sterilizing immunity meaning that if you get a vaccine, you are at zero risk for transmitting infection. But that was not known, and probably unlikely for a vaccine like COVID with -- that has -- affects mucosal surfaces.
So I think there were some optimistic hope about how effective that, the COVID vaccine would be to reduce forward transmission. However, I think there's also concurrently data to show that it does reduce forward transmission, as we discussed earlier, amongst household contacts, in prison settings, data

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that were collected in and through this period of time, and I think still is likely true today. Although I think we have to counsel that that's always informed by things like what variant is around, and how long it's been since somebody's had a COVID infection, and things like that.
Q In the summer of 2021, when UVA was making decisions regarding adding COVID, the COVID vaccine -- well, I just want to ask you a clarifying question on terminology. If I say COVID vaccine, do you understand that I mean the available COVID vaccines? I guess it's a little clunky to always refer to it in the plural. But will you understand -- just, will you let me know if you think I'm referring to one vaccine, but not other COVID vaccines available in 2021?
A I will. And I will say that I will be answering for the vaccines that we were using.
Q Okay. Thank you.
So with respect to the addition of COVID vaccines as a mandatory vaccine for some or all UVA Health team members in the summer and early fall of 2021, with respect to the issue of -- we just talked a

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bit about employee absences related to COVID, and the hope would be to reduce those absences. Just -- do you recall that?

A Yes.

Q Did UVA consider the fact that employees who would not or could not receive the COVID vaccine, mandatory vaccination would result in termination for some of those employees?

A I know that that was -- yeah, that was part of the discussion around whether to make it, you know, encouraged versus, you know, mandatory.

Q So did anyone at UVA weigh the -- with respect to absences, did anyone weigh the potential for additional absences or additional length of absences related to COVID for unvaccinated employees versus a, some certain number that would be terminated as a result of mandatory vaccination? So that would be a, obviously, long-term absence until their position was filled. Fair?

A I know leadership brought that up. They asked about the -- you know, in those discussions, what is the risk of having team members leaving the

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institution and exacerbating our staffing shortages, versus the opportunity to close staffing shortages by having a higher vaccinated workforce? So yeah, those were part -- I don't know if there were quantitatives, but there was that, sort of that risk assessment.

Q Yeah, so that's -- I guess that's my question. The issue was -- UVA leadership was aware that there was a potential for employees to either leave voluntarily or leave because they could not be vaccinated, versus reducing employee absences due to higher vaccination rates, how -- how did UVA weigh that issue?

A Well, I can't speak for all of UVA. I will speak for my perception of this. What I counseled is that as more health care institutions in Virginia, in our region, made the COVID vaccine requirement -- made the COVID vaccination part of the requirement, I was concerned that the relative proportion of our new team members that would come onboard would be coming on to UVA because we did not have a COVID vaccination requirement, and therefore, we could even further exacerbate our COVID vaccination -- or our COVID

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exposure furlough issue, and that we would become a safe house for unvaccinated team members and exacerbate our problem.

Q So what you were just referring to is risk on the side of not implementing a vaccine policy. But with respect to implementing a policy, you understood that there was a risk that employees might leave, or employees might be terminated because they didn't comply with the mandatory vaccination. How did UVA consider the risk on the other side?

A Yeah. I think -- I mean, I acknowledged that. Again, in my role as the hospital epidemiologist, understood that that was a risk. We had had the experience of influenza vaccination to understand that that was likely a risk. We don't know how many people maybe left the institution because of influenza vaccine requirements, but we had heard that there were -- there was that. And we had also heard that as other health systems adopted vaccination requirements, that that was -- had been seen at other institutions. So, it was an acknowledged risk.

Q And was there anything done to quantify

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that risk or look at data with respect to that risk?

A Not by me.

Q Well, you're testifying on behalf of UVA Health with respect to their --

A For part of UVA? Yeah.

Q -- decision-making process. I guess that's -- and you understand that I'm asking questions about the decision-making process? Do you understand that?

A Yeah. And just, again, understanding I'm answering those for the data that I had and was informing at the time. And so I did not have that data nor was asked regarding those risks. That data or some of that qualitative verse quantitative, semi-quantitative data may have been information that was being used by leadership looking at employee health and the absenteeism issues that we discussed earlier.

Q When -- when these issues were being considered by leadership at UVA Health in summer of 2021, leadership -- well, I guess by leadership, I just mean those individuals involved in

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decision-making. Do you understand that?
A Yes.
Q And so those individuals, those leaders, they thought about, or there was consideration of the fact that other institutions were also requiring vaccination. Is that fair?
A Yes.
Q And was part of the consideration that employees would likely be vaccinated, because they would have difficulty going to another institution if every one of those institutions implemented a COVID vaccine requirement?
MS. McGRAW: Object to the form, calls for speculation. You can answer.
A Yeah, I don't -- I'm not aware that that was a consideration.
BY MR. DIEHL:
Q What did UVA Health do to consider the risk of just not having positions filled if employees left or were terminated due to the COVID vaccine requirement?
A Not having positions filled and being

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understaffed was a daily challenge that we were working with every day. And so, that -- that was not a new challenge. That was a challenge that was occurring ongoing, that -- it was part of our -- you know, part of the daily calculation of, How can we continue to provide services for the health system?
Q Did UVA weigh the relative risk of we can't fill certain positions and, therefore, we might be short-staffed, versus we have this benefit of potentially having a higher COVID vaccination rate. Was there weighing of those risks?
A Yes. I think that that -- there was an understanding, and getting back to the discussion earlier, you know, that was part of the conversation that started in May. What is the benefit in terms -- in terms of employees and reducing furloughs compared to what the potential cost of having health care providers, team members, leave because of a vaccine requirement? That was part of that discussion from, from May I think, as I recall.
Q I guess -- so, what was done to quantify that, or put some data -- match up data with weighing

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those risks? Was there any sort of specific effort done to, to analyze those issues more deeply than just being aware that they existed?
A So you've asked that multiple times, and I'm not aware of quantitative data that's been used -- that was used for that. There was a challenge of the counterfactual at the time. What was the -- you know, what was -- what would happen with current state if there was not a vaccine requirement? That was part of the discussion, but also it was an unknown. How many people would leave the institution because of a vaccine requirement? We had no idea. At least I had no idea, other than what I referenced before, to saying that we had anecdotally perhaps some people that left the health care institut -- left UVA at the time of the influenza vaccination requirement, you know, back in 2010 or something like that. But I don't know what the number was.
Q There are employees at UVA who are -- whose responsibilities include recruiting new employees. Fair?
A Fair.

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Q Was anyone specifically involved in recruiting at UVA, at UVA Health, were they brought into the discussions about the change of the COVID vaccine policy to try to understand the -- any difficulty or hardship involved in finding new employees to fill positions that were, that were empty because of a change in the policy?
MS. McGRAW: Objection, beyond the scope. Incorporate our objections to the notice.
A I'm not aware that they were brought in to make conversation or that calculation. They may have been, but I was not part of that, of those discussions.
BY MR. DIEHL:
Q It's -- in any given day you can go on UVA Health's recruiting website and pull up the number of job openings that are available. Did -- as part of the decision-making process with respect to changes in the COVID vaccine, do you know of anyone that pulled up that information and said, You know what? Today we've got 1500 open positions. Maybe we shouldn't -- maybe we shouldn't do this. I'm not saying that

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occurred, but did anything like that occur?
A Not that I know of.
Q Do you know why not?
A I don't know that it did or did not. It very well may have. But it did not in the leadership meetings that I attended.
Q And you know you're here to testify about the decision-making process today?
A And I do.
Q Okay.
A And I'm referencing the information that I know. And during that decision-making process, these are questions that very well may have come up, and I would be -- I could anticipate they maybe did occur, and others can speak to it. But I have no relationship with HR, and I don't know what the HR process is, or -- and never heard discussions -- they didn't involve me in discussions regarding whether they felt a policy would -- like this, like was adopted, would be a recruitment challenge or not.
MR. DIEHL: It's probably a good time for a short break.

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MS. McGRAW: Okay.
(Recess taken, 2:40 p.m. to 2:48 p.m.)
BY MR. DIEHL:
Q We took a short break. Thanks for that.
Before lunch, we talked a bit about the COVID vaccines, and the COVID virus itself, and the mutations. I'm trying to ask this in a way that, again, like you're explaining it to a lawyer who is sort of the equivalent to like a seventh grader on this. Maybe not seventh grader, but like a smart tenth grader. Can you just sort of briefly explain how vaccines work?
MS. McGRAW: Any particular vaccine, Sam?
BY MR. DIEHL:
Q Well, I'm talking about -- yeah. So it's obvious we're talking about COVID vaccines, and I just want to sort of generally understand how the COVID vaccines we're talking about worked. Yeah. How do they function?
MS. McGRAW: Okay. I'm going to object to the form.
A Yeah, it is, boy, a big question. But I will try to answer it for a tenth grader. And I will try to limit it to, you know, sort of a general understanding of the COVID vaccine.
So the goal of the vaccine is to present a part of the virus, because we're going to talk about viruses, in this case, SARS CoV-2, that are -- have a couple properties. So one is that they're required for the virus to function; that they stimulate an immune response that is protective, and that, you know, I think probably -- those are probably the two good places to start. So they're required for the virus, and they stimulate an immune response.
BY MR. DIEHL:
Q Yeah. And I don't want to interrupt you, but obviously to try to get to kind of the point a little bit more.
A Okay.
Q We talked about sort of the immune response to COVID without a vaccine. Is it fair to say that there's an immune response from the body, and obviously, if the person doesn't die, that immune response can help prevent a new COVID infection. Is

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that fair?
A That is --
MS. McGRAW: Object to the form. Go ahead.
A Oh, I'm sorry. Yes, that is fair.
BY MR. DIEHL:
Q And is the idea with the vaccine to sort of help prompt that same immune response? Is that a shorthand, or is that not accurate?
A It's mostly accurate. It is to stimulate an immune response that does not involve infection. It's probably worth saying that the immune response can be somewhat different, and, you know it is probably fair to say it's a, it's a portion of the immune response, so, you know, a version of the immune response to a -- that part of the protein, or that part of the, I'm sorry, the virus, it's important for infection and the immune response to infection can be different, tend to be different.
Q Different between a vaccine-prompted response versus a body-generated immune response?
A Right. So there's corollaries. There's parallels. They are not a one-to-one match.

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MS. McGRAW: I'm going to get some objections on the record that this line of questioning is beyond the scope, and he's not here to provide expert testimony today. But you can continue.

BY MR. DIEHL:

Q So I guess I'm coming to why this -- I'm going -- I want to eventually ask why this might matter for policy making. But we talked about mutations of the virus and different variants of the virus. Do you recall that?

A Yes.

Q And so did those variants make a difference in terms of one's body's immune response from a previous COVID infection? Do you know?

MS. McGRAW: Same objections. Go ahead.

A Yeah. From the way you've phrased it, I think I'd actually put the -- it's the other direction. Your immune response is, you know, that there's robustness -- maybe I'll use that word -- but there's robustness differences between different variants. Does that --

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BY MR. DIEHL:

Q And does the immune response, does that corollate to symptoms of having COVID? Is that -- is that a correlation?

MS. McGRAW: Can I just get a standing objection?

MR. DIEHL: Sure.

MS. McGRAW: Thank you.

A Um, gosh. Um, in general, more symptom -- more symptoms are reflective of a stronger immune response in general. But there is, of course, exceptions both directions.

BY MR. DIEHL:

Q So I guess my question is, or a related question is when the vaccine mutated --

A The virus.

Q It's the same word -- same letter, but let me start that over.

When the virus mutated, I understand there were changes to the vaccine, or -- well, maybe changes to the vaccine is the wrong term. Well, it's my understanding that at some point boosters were

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created. Is that -- do you know what I -- what are boosters? And we'll refer to the fall of 2021.

A Fall of twenty -- it's again, a term -- you know, terms that some of us were not fans of, that we wanted a third dose of vaccine, or the next dose of vaccine, right? But booster is a vernacular probably used to say another dose of vaccine to restimulate the immune system.

Q And did the -- so, you say that a third dose or a new dose of the vaccine is a better term than booster?

A Yeah, I think so, because -- yeah.

Q So I'm just going to use the term "new dose," just to pick one.

A Yeah.

Q So why would a new dose of vaccine be necessary because of a variant of the COVID virus?

A Okay. So this is a broad question, and if you'll indulge me, it goes into sort of virus biology and vaccinology a little bit, if that's okay.

Q Sure.

A Okay. So an immune re -- so the immune

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response to COVID or to the product that the vaccine produces, which is the spike protein, again, that protein that latches on to human cells and is the target of neutralizing antibodies, the antibodies that kill the virus or kill virally-infected cells, that immune response is multifaceted. It includes, again, the antibodies, we call that the humoral immune system, and there's also cellular immune responses, including specifically cytotoxic T cells. And I've used this analogy in the past. One way to think about this that's, I think, kind of accurate when you're thinking about the spike protein is a stalk of asparagus. The stalk of asparagus, the outside part of the asparagus is the, sort of the working end of the spike protein. That is the thing that latches on to the ACE2 receptor that's displayed on human cells. That's how a virus attaches, docks to a cell, and then eventually gets inside. But that stalk also has the stem and all the other parts of the piece of broccoli to get up to that point.

The cellular immune response is directed towards parts of -- that are elsewhere in that

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broccoli: In the stem, maybe in the crown, maybe in a leaf. Elsewhere. And so the cellular immune response is important, because that's the part of the immune system that produces memory. And what memory is is the ability to remember that this thing, this broccoli stalk, this spike protein, is not, is not me. It is a foreign invader. And so when it's seen again by the immune system, it can be the general that activates the army, and then causes the production of antibodies, the B cell or humoral part of the immune system, and then the cellular immune system, the cytotoxic T cell system. So both of those systems can, therefore, then, you know, fight infection, as -- you know, triggered by this broccoli stalk.

There's also a third part of the immune system that I won't go into that's called the innate immune system, but just basically recognizes that this is a virus and not human. And that's triggered as soon as the body sees it, or like, within -- you know, within a very short period of time. And that stimulates the entire kit and caboodle. So innate immune response stimulates, then the adaptive immune

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response that's composed of antibodies, which are the humoral immune response, and then the cellular immune response.

Q So, I guess, why would any of that be affected by a new variant of the COVID virus?

A Yes. So, the -- what happens with a new variant is that it changes the composition of the broccoli stalk, so that those antibodies don't recognize it as readily. So antibodies live for a period of time in the body. They eventually sort of go down if there's not some continuing stimulation for their production. If we stimulated all the antibodies that we could produce, our blood would be like Jell-O. So we need to sort of shut down those processes at some point. So you produce it, they're around for a while, and then after a period of time they sort of, you know, slowly dec -- are reduced, and then, you know, even close to disappear within the immune system.

The broccoli stalk, again, the variant changes, that spike protein changes. Those antibodies can get revved up, but maybe they're not quite as

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effective because that broccoli stalk has changed as it's mutated and evolved. But the cellular immune response and the innate immune response that sort of triggers the whole thing, those things haven't changed. And so they stimulate the whole process. And ideally what happens is when you have that new antigen that's displayed on that spike receptor, sort of that evolved version of the broccoli stalk, new antibodies are formed that can attack that broccoli. It's also important to say that the old antibodies that were produced before also probably are effective to some degree, but perhaps less, if there's a mutation that's specific for that -- you know, that neutralizing antibody. So maybe if it worked a hundred percent before, whatever that measure of a hundred percent is, maybe it's only 80 percent now. But it's still effective.

And so what's the concept of a booster? The booster is, it gives you that spike protein. It's showing your immune system that broccoli stalk again. It revs up the cellular immune response to produce more antibodies, those B cells that are the factories

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of the antibodies get revved up, they produce the antibodies, and they're there -- they're then able to combat or fight that new variant. Maybe not quite as effectively, but still, hopefully, pretty effectively. And then as you've seen through the pandemic, the evolution in vaccinology is to say, Okay, let's actually update the spike protein, you know, that's being produced by the vaccine, whether it's a protein vaccine, or an mRNA vaccine, or, not in the U.S., you know, other vaccines to update that spike protein. So you've changed that broccoli stalk, the antibodies, that broccoli stalk displayed, so those antibodies are updated now, better able to combat that new version of COVID, that variant.

Q When the -- there was some press reports about the vaccines are -- the original COVID vaccines are effective for a certain period of time, and then one needs a booster or a new shot. What -- what was being referred to about the period of time that the initial vaccine was effective?

MS. McGRAW: Objection, beyond the scope, calls for speculation. I think if -- you can show

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him, put a document in front of him if you're asking him to comment on a document.
BY MR. DIEHL:
Q Do you know what I'm talking about?
A Uh-huh.
Q That's "yes"?
A Yes.
Q Yeah. So, if you could explain what was referred to in -- and I'm talking about -- well, let me say this: There was -- I see there was a discussion about boosters in sort of the early fall of -- like late summer, early fall of 2021. Does that sound correct to you?
A Well, there certainly was conversation then. But I'll say that the concept of need for boosters dates back to the start of the COVID vaccine. So my recollection is when we first started vaccinating our health care providers, they asked, Will we need to get an annual COVID shot like we need to get an annual flu shot to provide protection? And the answer at that time was, I don't know. We'll see. I think that's the exact same answer the CDC gave, and

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the sort of the other experts that would be asked about that would. It was, We don't know yet.
And so yes, that conversation also occurred, you know, through the initial vaccination process, and certainly, you know, continued into the fall of 2021.
Q In -- I -- I've seen information where boosters really -- the CDC I believe recommended boosters beginning in about September 2021. Does that sound correct to you?
A That sounds, yeah. Yeah, I think that was during the delta that you were talking about -- we were talking about three-quarters before.
Q Yeah, that's what I was going to ask. Was that related to the delta variant mutation?
A I think -- I think now in retrospect it was due both to that and to the loss of humoral immunity that we were talking about. But I think it was both factors, both the -- yeah.
Q Is the loss of humoral -- and how do you spell "humoral"?
A H-U-M-O-R-A-L.

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Q Is that like the humerus bone?
A It's like humor, which is blood. Plasma or blood.
Q Okay. So with respect to humoral immunity, is that -- what you're referring to there, is that sort of like the vaccine kind of waning in effectiveness over time, just kind of wearing off? Is that a fair analogy?
A It -- the analogy I would use is that it's the loss of the antibody response that we talked about earlier.
Q And so --
A Well, and again, it's not loss. It is just a declination. So risk is sort of, you know, sort of the antibodies go down over time, and risk for infection then goes up over time.
Q By the fall of 2021, was there an understanding that the initial COVID vaccine's effectiveness would have waned sufficiently either because of losing effectiveness or diminishing effectiveness, or because of a new variant, that they'd become ineffective or less effective by the

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fall of 2021? Does that sound correct?
MS. McGRAW: Objection, compound.
A So, we talked earlier about the Barnstable experience in Provincetown, in Barnstable County. I think that that was an example of that where, after a period of time of somebody being fully vaccinated, developing infection. What I think was less recognized and I think not well covered in the media, or perhaps maybe not as clearly expressed by many of us, I feel I worked hard to do this, is to differentiate infection from disease and severe disease. So, broadly speaking in terms of vacc -- the vaccine used for, for the population, the COVID vaccine demonstrated continued excellence at reducing hospitalization and death from COVID. And, um, what was seen was that after a period of time, infection and mild disease was less well protected.
BY MR. DIEHL:
Q Would the, the difference in those two issues, the sort of severity of the illness versus prevention of -- well, what's a short -- what was the last -- I don't want to mischaracterize it, and I feel

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like I missed. So the first issue you mentioned was reducing hospitalization or the severity of illness. Is that a fair shorthand?

A Yeah. So um, I think then and, as been consistent through the pandemic, vaccination has proven to be very robust to be protective against hospitalization, and particularly severe hospitalization outcomes, ICU care for example, and death.

Q So -- and then the other issue would be contracting the virus, having symptoms, spreading the virus. Is that fair?

A That's right. So mild infection, or well, you know, what you could say is mild disease versus asymptomatic infection. That was the higher bar, very difficult, I think, for any vaccine to sort of have that type of effect over a long period of time.

Q And when we're talking about the fall of 2021, that second issue, that issue of symptoms or contracting the disease and having mild symptoms, but still having symptoms, that's the issue that had waned in effectiveness from the vaccine by the fall of 2021?

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A Yes. I think that was what was being observed, and that I think led in part to CDC -- FDA's and then CDC's, and then advisory committees to make the recommendation for a third vaccination in a normal host, you know, a so-called booster dose. But there was also -- because I really don't want to paint too broad a stroke here -- there was also a recognition that, you know, while I said it was still robust in preventing hospitalization and death, there was evidence, as I recall, that there was, um, some increase, there was a notable increase, a significant -- you know, statistically significant and meaningful increase in disease leading to death and ICU stay, and hospitalization that was occurring particularly in higher risk populations, patients that were older, age 65 or 75 years of age and older. And before that, in immunocompromised patients, which is why a third dose of vaccine became recommended well before that for immunocompromised patients who just, because of their immune system, are less -- have a less robust immune response to vaccination. So it's in that context that a third booster was recommended for, you know, for the U.S. population.

Q And in -- and I'm correct that that recommendation, at least from the CDC, came out in I believe September 2021; is that correct?

A About, yeah.

Q And then it's my understanding that UVA Health did, at one point, decide to require a third dose of the vaccine; is that correct?

A That's correct.

Q And when was that?

A I'm gonna refer to my dates again, if that's okay.

Q Sure. If you'll just tell us what page you're referring to.

A I will do that. I'll give that number. It was December 23rd, 2021. And UVA 372.

Q And that's behind what tab in the binder?

A Number seven.

Q So with respect to that change, it's my understanding that that policy change did not last. It was another change. When was the next change related to the issue of a third vaccine or boosters?

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A That was January 19th, 2022.

Q And what was that change on January 19th, 2022?

A Yes. And I'll just say it was behind Tab 8, and that was to remove the booster requirement. So that, I guess, third dose or booster dose requirement was stopped at that time.

Q So why did -- so fair to say that in December, UVA determined that boosters were necessary, and necessary enough to mandate that employees receive the booster or third shot. And then why did that change to not requiring it in January?

A There were two factors. So the first factor is that this was the start of the height of the omicron wave, and the health care workers, we were all stretched so much that closing and finishing the required booster vaccination was challenging work that required time and effort, and it was overwhelming at the time. That was one factor I think.

The other factor, in my estimation perhaps the broader, bigger factor was that Governor Youngkin took office, and had an executive order shortly after

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he was in office saying that vaccination, booster vaccination, or vaccination could not be imposed on state employees. But paraphrasing.

Q It was my understanding that there was a -- well, first of all, what is CMS? If I say CMS, do you know what that refers to?

A Centers for Medicare and Medicaid Services.

Q So federal agency that's part of the Department of Health and Human Services?

A Correct.

Q And that agency is involved in paying for -- funding Medicare or, and Medicaid; is that correct?

A Yeah. For reimbursement of Medicare and Medicaid services, yes.

Q And so I understand -- I understand that there was a CMS mandate, for lack of a better term, or CMS rule related to COVID vaccination. What was that?

A That was -- yes, there is. Or was. And that was instituted on or around the first week of November, as I recall. Don't quote me on the exact date, but yes. A requirement for COVID vaccination --

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COVID, I guess, primary vaccination, which was again two doses of the messenger RNA vaccine, or at the time, a dose of the Johnson and Johnson vaccine.

Q But in the fall of 2021, I thought that the third dose was kind of the -- well, I don't want to put words in your mouth. Was the third dose important in the fall of 2021, the third dose of vaccine?

A I'm not sure what "important" means in your context, but it was what was recommended by the CDC. But -- yeah. CMS required completion of the primary series. They did not require a booster dose.

Q Well, do you know why, why the CDC recommended the third dose of the vaccine, what has been referred to as a booster dose of the vaccine in the fall of 2021?

MS. McGRAW: Object to the form, beyond the scope. Go ahead.

BY MR. DIEHL:

Q Yeah. And I should -- I think I might have said "required," but the CDC recommended; is that correct?

MS. McGRAW: Same objection.

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BY MR. DIEHL:

Q Okay. So why did the CDC recommend a third dose of the vaccine in the fall of 2021, as opposed to just recommending the original vaccine?

MS. McGRAW: Same objection, asked and answered. Go ahead.

A Yeah. So -- and I didn't answer it fully last time. Again, the epidemiology was demonstrating that individuals, particularly at-risk individuals who were elderly or had other increased risk factors for COVID, were starting to have an increase in, in, um, negative severe outcomes of COVID compared to individuals who had a third dose of vaccine or were more recently vaccinated. My recollection is that most of that data -- much of that data came from places like Israel that had nationwide vaccine programs and had strong epidemiology that informed those decisions. And so the CDC made that recommendation to get a -- for -- for a third dose, or boosters of the vaccine, at the time based on the data that they analyzed in August-ish/September-ish 2021.

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BY MR. DIEHL:

Q The CDC is part of the Department of Health and Human Services, isn't it?

MS. McGRAW: Object to the form, beyond the scope. Go ahead.

A I think so. But yeah, I'm not a government wonk, and -- yeah. I believe so.

BY MR. DIEHL:

Q I'm not asking you to guess, but do you -- similarly, with respect to CMS, do you know why CMS didn't say, We recommended getting the third dose or just the booster shot, or all three doses of any COVID vaccine?

MS. McGRAW: Same objection, beyond the scope, calls for speculation. You can answer.

A I don't know, and in -- I had wondered the same thing, and wondered if there would have been a decision to actually add a booster requirement at some point. But that never occurred.

BY MR. DIEHL:

Q But specifically to UVA, the decision was made to add the booster requirement, and then the

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decision was revoked as a result of Governor Youngkin's Executive Order; is that correct?

A Also with the caveat that in the middle of omicron, it was very challenging to close that, you know, the -- I want to say the vaccination gap. A lot of it, again, was just the information, the information process. Like, who's been vaccinated? Who's got a booster? Who doesn't have a booster? But yeah, I think that the governor's decision was, was key to that.

MS. McGRAW: And Sam, I'm just going to note, I want him to be able to answer your questions, and I think he has, but if we're going to get into discussions with counsel about the impact, I want to stay away from that.

MR. DIEHL: Sure.

BY MR. DIEHL:

Q I'm not asking about anything that lawyers have said about Governor Youngkin's Executive Order.

But you mentioned something a few minutes ago about being stretched so thin; that that was -- that was a factor as well in early 2022, while the

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omicron virus was at its height, I think you said, that was a factor as well?

A I -- yes.

Q And it was a factor with respect to UVA's decision to not require the third dose, or a booster dose of vaccine, of the COVID vaccine?

A It was certainly a stress. In terms of leadership, I don't know how heavily they made that calculation, but certainly Occupational Health Services were very challenged to try to do the vaccination, do the accounting of who'd been vaccinated, who hadn't been vaccinated, and help take care of, through the health care management, of team members that had COVID. And we had hundreds of health care workers who had COVID.

Q And being stretched so thin, part of that is just needing more staff to do all the things that health care staff do, correct?

MS. McGRAW: Object to form, beyond the scope.

A Yes. The efforts to take care of the patients that were being seen in the clinic and -- clinics and in the hospitals with less workforce, yes.

BY MR. DIEHL:

Q Um, did, did UVA ever consider the fact that terminating several hundred employees in the fall of 2021 might have contributed to being -- staff being stretched thin?

MS. McGRAW: Object to the form, mischaracterizes the record. Go ahead. You can respond.

A I have no recollec -- I have -- not that I am aware of. That was never a discussion that I was involved with at that time.

BY MR. DIEHL:

Q Do you -- at the time you -- well, so you personally were involved in leadership decision-making with respect to the change in policy to add the requirement of a booster and then to remove that; is that fair?

A I think it's fair to say that I was an advocate for the vaccination, and as part of -- yeah, considered leadership team under the -- I'll go back to my original comments that I was subject matter

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expert, all that, so I was not part of the inner part of an executive leadership. But yes, I was part of that.

The discontinuation of the booster requirement was something that I was not, you know -- it was announced, and I think that I -- you know, that we needed to do this in reflection of what was going on with the census, and Dr. Youngkin's -- Governor Youngkin's Executive Order.

Q What do you mean by the census?

A Census is, like, the number of patients in the hospital. I'm sorry.

Q That's okay. I mean, I -- that's why -- that's why I ask questions.

So, wait. So leadership at UVA Health made a decision to add the booster shot as a requirement as part of OCH-002 in December 2021, correct?

A Yes.

Q And then -- and then there was a decision made in January to remove that booster requirement, correct?

A Correct.

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Q And I'm trying to understand -- you know, I asked about you personally being involved in those decisions. I'm not -- I understand from your -- well, is it -- I understand from your earlier testimony that you were asked questions, and you helped inform the decision-making process with respect to COVID vaccine policy changes; is that fair?

A That's fair.

Q And so with respect to either the December 2021 or January 2022 change, did the leaders and decision-makers at UVA Health ask you questions to inform their decision-making?

A Yes. So, between -- well, I'll say -- coming up to the December 23rd revision, yes. So with the revision of the policy on December 23rd, yes. With revision to the policy on January 19th, um, as a governor's executive order, I think that there was not much discussion, and certainly not discussions with me as to whether I felt we should follow the governor's order or not follow the governor's order.

Q And I'm not asking about any attorney-client privileged discussions, but did

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leaders of UVA Health come to you and say, What is the risk of making this policy change? What is the danger in making this policy change?

A On January 19th?

Q Well, sometime before January 19th I guess it would have to be, right?

A Yeah. I think it was January 18th perhaps. So no, that question didn't come to me.

Q Did you have an opinion about boosters --

MS. McGRAW: Objection, beyond the scope.

BY MR. DIEHL:

Q -- after the -- well, you -- let me ask -- let me step back. Strike that last, whatever that was, gobbledygook.

With respect to the December 23rd, 2021, change, --

A Yeah.

Q -- you were an advocate for adding boosters, correct?

A Yes. Yeah.

Q Why?

A So omicron, I saw the first reports of omicron on Thanksgiving week, one month before that, the initial reports from South Africa. I was working in the hospital, my family was away, and I was attentive to what was going on, because nothing else going on in my life except for taking care of patients. And so I saw those initial reports, and was very concerned by what I saw within, within a week of how quickly omicron was spreading in South Africa, and early reports of its spread in other places like, like Europe.

This was also of concern to people in the rest of the university and health system as, for example, students are away finishing up finals, and then going to be, you know, heading for holiday, dispersing around the country and around the world, and then come back to UVA to start spring semester. So that's the university part. And so there was a desire at the university to protect -- not protect, but to have as immune a student population and student faculty community as possible. And so the -- there were discussions with the adoption of a booster requirement for students in or around that time.

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In the same way, I was concerned with the breadth and significance of what appeared to be the omicron wave, what became the omicron wave, that the -- an important tool that we had to try to maintain operations would also be to have a highly-vaccinated workforce. And so I recommended a booster requirement, which the CDC by that time, as outlined previously, that you outlined, had been a recommendation for healthy adults a couple months earlier. So it was a recommended vaccine, and we adopted it as to a requirement in the face of what appeared to be a tidal wave of infection that was circulating around the globe.

Q Um, and you said that concern arose when your family was out of town? Was that over Thanks -- did you say that was Thanksgiving time period?

A It was thanksgiving week, yeah.

Q So Thanksgiving 2021, whenever that occurred?

A Yeah. I think it was Wednesday, if I recall, is when I saw the first reports. It was Tuesday or Wednesday.

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Q I don't suppose, if you're a medical provider, people don't stop getting sick when you want to eat turkey or whatever, so you have to continue to work over the holiday?

A It's pretty common that I'm working on a holiday, Thanksgiving or Christmas or New Year's, every year.

Q You were involved in -- well, I guess, were you personally involved in issues related to any analysis regarding what is or isn't an undue hardship when employees are granted an exemption from a vaccination requirement?

A Yes.

Q And with respect to undue -- the issue of undue hardship, whatever that hardship might be, is the hardship different when an employee is unvaccinated as a result of a religious motivation or belief as opposed to a medical issue that prevents vaccination?

MS. McGRAW: Objection to the extent you're asking for a legal conclusion.

A So my understanding, especially later,

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because when I was first asked about this, I didn't understand, or was not familiar with the term "undue hardship." But I was advised -- no, no, no, no. Okay.

MS. McGRAW: We're not going to talk about what -- yeah.

A What I was advised? No.

BY MR. DIEHL:

Q No, I'm not asking about what you were advised. I'm just asking what you understood an undue hardship to be in either the -- and I'm talking about in the fall of 2021.

A Yeah.

Q So with respect to an exemption related to a medical issue, or an exemption related to a religious belief or practice.

MS. McGRAW: And same objection with respect to the legal conclusion. I think you can ask him what the analysis was, but I don't think you can ask him what an undue hardship is under the law.

BY MR. DIEHL:

Q Well, I'm not asking about -- well, you

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testified that you were part of the process of analyzing undue hardship, correct?

A Correct.

Q And so you had to have some understanding to analyze that issue, correct?

A Correct.

Q So what was that understanding you used?

A So my understanding was that I would do an analysis to see if a person who had an exemption due to a medical or religious reason represented a significant risk and, um, and I'll use the term now, an undue risk for a specific location in the health system. And so that could, you know, probably most easily be defined as a, you know, high-risk population.

Q And how did you determine -- how did you make that determination?

A So I used my, my clinical experience as a hospital epidemiologist and an infectious disease physician that specializes in highly immunocompromised patients with organ transplants and cancer. So the approach was to identify those patient populations

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that were either highest risk for poor outcomes due to COVID, or -- and/or didn't respond to the therapeutic interventions that we had available like vaccines. So, you know, in that analysis, a patient population, as an example, cancer patients who have had a bone marrow transplant, who don't respond to vaccines after vaccinate -- you know, after immunization, or an organ transplant recipient that cannot respond to a vaccine, those were examples of populations that were at high risk -- I deemed to be highest risk for complications from COVID.

Q So you mentioned cancer patients. Was it all cancer patients, or just certain types of cancer patients?

A It was really targeting leukemia, lymphoma, bone marrow transplant patients, those are the patients that are, have, you know, either cancer of their immune system or have had bone marrow transplants and are on immunosuppressive medications that have long periods of time, months, if not indefinite, where they don't respond to vaccines and are at significant risk of these types of infections,

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which we saw clinically in patients who had bad outcomes due to COVID.

Q Other than those patients that you just described, what other -- were there any other patients that you determined were at substantial risk, or I guess -- well, any other patient populations that you determined were relevant to your undue hardship analysis?

A Yeah. It was a case-by-case basis, taking a look at, you know, the patient groups that that specific health care worker would be working with, and those were the, what we've just described -- what I've just described, cancer and bone marrow patients and leukemia/lymphoma patients are the, you know, the vast majority of pat -- well, I think they're the only examples that I recall having undue hardship analysis sort of come up. There could be others that I could think about, but they didn't come up.

Q What -- sorry. What would have been those others that would have been such a high risk that it would have been a much higher risk than, say, other -- working with other patient populations?

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A You know, an inpatient geriatric clinic or something like that, I think I would have had some -- you know, I would have concerns about.

Q Any other patient groups or treatment areas that would have been substantially high risk than others?

A Um, I think I'd say that those were the highest risk that I considered.

Q I guess, would there have been any others based on your knowledge of the hospital and COVID in the fall of 2021, would there have been any other areas where you would have determined that a patient with an -- or excuse me, an employee with an exemption could not work in the fall of 2021?

A Yeah. I think those are, those are the ones that I can on -- those are the only ones that I can think of. And it was important, I also said this, it also was important to think about what that health care provider did, what their interaction of patients was, you know, their potential -- you know, the potential for exposure in those locations.

Q So, it would be individuals who worked

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directly with cancer patients, targeting with leukemia, lymphoma, and then inpatient geriatrics. Can you -- can you, as you sit here, think of any other areas that would have been determined -- you would have determined that employees with an exemption could not work there?

A Yeah. Not off the top of my head. And I'll say that inpatient geriatrics is a theoretical, because we don't have such a unit. So those are the ones.

Q What about -- what about dialysis?

A Dialysis represented a patient group that are increased risk, but not a -- not as high risk.

Q What about the emergency room?

A Oh, definitely not the emergency room. So part of this analysis was this patient population primarily represented -- so this is sort of -- the high-risk patients are who you are dealing with most of the day, as a clinician, most of the time. A place like an emergency room, you're going to have 20-year-olds, 40-year-olds, and high-risk patients all in that same patient population. And that's true, you

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know, across the health system. You can go to a private practice and they'll have high-risk patients interspersed with low-risk patients.

Q And if you take your time, look at any documents before you, can you think of any other patient populations that would be too high of a risk to allow individuals with an exemption to have worked with them in the fall of 2021, regardless of whether you did or not, didn't make that determination?

A You know, I can think of other practice settings that aren't represented at UVA that would give pause to concern. If you had --

Q And I should caveat that. I'm asking about UVA, at UVA, not theoretical settings.

A So yeah. So without theoreticals, no.

Q And I started to ask about this, but I don't know that I actually got done. Was the analysis with respect to those risk populations and working, having been granted an exemption, is that risk analysis different if the person is unvaccinated because of a medical reason as opposed to if they're unvaccinated because of a religious reason?

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A No. That's not how I did those determinations.
Q The analysis of the risk and hardship would have been the same?
A Yes.
Q And you did -- as part of your analysis, you did -- and I'm correct that you did not review any risks related to filling jobs, or figuring out whether this person could fill a different role at the UVA Health System if their job's terminated, and the risk of -- related to their termination, you did not evaluate that issue?
MS. McGRAW: Object to the form.
BY MR. DIEHL:
Q Well, that was a long clunky question, so I'll ask again.
We talked earlier about risks to the UVA Health System from employees being absent from the workplace.
A Yeah.
Q Fair?
A Fair.

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Q And did you, as part of analyzing the hardship in granting an exemption, did you analyze the risks of the hardship to UVA Health System's business and having workers to do that work?
A You know, that's a good question. I believe there was one that came up either -- I actually don't know, and I can't recall if it was a theoretical or if it was something that was worked out. But there was, as I recall, a number of employees that were not vaccinated, and I don't know for what reason, who worked in Sterilization and -- Sterilization. Sterilization and Disinfection, Sterile Processing. And there was a manager that reached out saying, We have a new hire that is in -- you know, is in this domain, and you know, going to be working in this capacity, and I already have a couple other individuals. Is that a risk?
And the analysis was -- and I don't recall now whether that team mem -- that health care team member, Sterile Processing person got vaccinated or they were working on a different shift, so the risk was reduced, but there was a discussion. I asked if there were to be a cluster of infections between these unvaccinated individuals so that they were either infected or exposed and furloughed, would you be able to maintain operations? And that was part of that discussion. That's -- I -- so there was that -- at least that example.
Q And by "that," you mean -- that being part of the discussion, that was -- the "that" in your answer was the issue of replacing the worker. It's -- they're having trouble filling positions? Was that what the issue is?
A No. It was more does this represent undue hardship, that if something were to happen, we would not -- would we -- would UVA be able to maintain the ability to do the surgery? So it was not the, Is there another place to accommodate the team member? Again, my recollection is that it sorted out, because the team member, you know, worked on a third shift, or it could have even been a temporary employee. But it ended up being moot.
Q So the issue was that we need people to sterilize equipment to do surgeries. It's going to be very hard for us if this person can't work here. That was the hardship? Is that what you were discussing?
MS. McGRAW: Objection, mischaracterizes.
MR. DIEHL: Well, I'm trying to understand.
A And so I can answer?
MS. McGRAW: You can answer. Just try to explain it again.
A I think I answered it, but yes.
MR. DIEHL: I'm not trying to --
MS. McGRAW: He just didn't understand it.
BY MR. DIEHL:
Q Well, I didn't understand it. I'm trying to understand --
A Oh. Yeah, yeah.
Q I'm trying to understand the answer. I'm not trying to put a different -- to be clear, I genuinely, like didn't understand the hyp -- not even the hypothetical, but the situation you were talking about.
A Okay. And I apologize for that, because I thought I was clear.
Q It's okay.

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A But yeah, that is exactly right. The undue hardship is if we have another person that's unvaccinated in this environment, there's other individuals who are not vaccinated as well, could we risk having a situation where these team members are furloughed or off of work because of infection or exposure and we are not able to process enough sterile equipment to continue to do surgery?

Q So was a decision made with respect to that employee to which you're referring that they should not be granted exemption because of that concern?

A So this is again my recollection, is that when I asked that question about what is occurring with that employee, they were working on a different shift or they got vaccinated, and so that theo -- I don't want to call it theoretical, but that concern ended up being resolved without having to say this person's accommodation can be met or not.

Q So you never made a determination specific to the potential hardship, because the issue resolved in some other means.

A Exactly.

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Q All right.

A So sorry about that. But it was -- I just brought it up as an example where it was entertained, but it did not happen.

Q And as you were making any determinations in the fall of 2021, were you able to determine the relative risk between allowing an employee to work while being tested, even though they're unvaccinated, versus having an employee work that was vaccinated but untested?

MS. McGRAW: Objection, asked and answered.

A Um, I think I did answer that before, that that relative risk calculation was not performed by me, or anybody that I know of in the health system.

BY MR. DIEHL:

Q And to the extent it matters, I'm asking about a -- I'm trying to ask about a different time period. So as opposed to the summer, I'm asking about the fall. But just to be clear about that, the analysis related to any hardships related to exemptions, that was an issue that you -- whatever you did to review that, that was undertaken in the fall of

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2021?

A Um, yes. So the hardships were evaluated in fall. And if it's okay, I'll answer the previous question, because I understand it now. So, again, that risk calculation that you just outlined between unvaccinated and tested versus vaccinated and not tested, like the early fall, late summer, that -- an analysis of that relative risk was not performed by me or people that I know of in the, you know, December time frame that you're speaking of.

Q Do you know why not?

A Again, I think because they were very difficult to measure, and we were busy dealing with a pandemic, and so both, what's the metric -- you know, how do you measure that metric and how do you have time to do that analysis when you're taking care of patient populations with COVID, and other things, trying to maintain operations?

MR. DIEHL: Do you need a break? I'm finding the way. I just am --

THE WITNESS: I'm good.

MS. McGRAW: I'm good.

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MR. DIEHL: So am I. I just lose track of time a little bit.

MS. McGRAW: Go another 15 minutes or so.

MR. DIEHL: Yeah.

BY MR. DIEHL:

Q So at some point UVA's policy changed again, and I'm talking about OCH-002, to omit any vaccination requirement; is that correct?

A Yes, that is correct.

Q And when was that?

A A couple versions. August 4th, 2023.

Q Why was the August 4th, 2023, change made?

A That coincided with the removal of COVID vaccine requirements by CMS, by the Centers for Medicare and Medicaid Services.

Q And other than CMS, any change by CMS, did you advocate to maintain the requirement for COVID vaccination or implement a new requirement in 2023?

A Um, I did not advocate for it, but I -- that was a calculation that I made understanding that -- my understanding, that is not that of a lawyer's, but with the removal of CMS's requirement,

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that Governor Youngkin's Executive Order, while perhaps challengeable as a health system, that would have led to those types of discussions.

Q Did -- who at -- to your knowledge, do you know who at UVA Health was responsible for complying -- compliance with the CMS rule or mandate?

A Um, well, you know, we have an office that specifically deals with regulatory issues to make sure that we are compliant with all CMS requirements, as well as other, other requirements, like the entity called the Joint Commission, which is not a governing body, but they do sort of -- are the -- probably the easiest way to describe is that they are the, you know, a non-governmental organization that's contracted to do evaluations of hospitals to make sure they're compliant with CMS rules and regulations. And, you know, so you have to follow their guidance in order to have, you know --

Q Is it sort of an accrediting process?

A It's an accreditation process. Thank you very much.

MS. McGRAW: I'm going to make some belated

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beyond-the-scope objections. I mean --

MR. DIEHL: I'm just trying to understand his testimony.

A So yes, there is an office that deals with that.

BY MR. DIEHL:

Q You mentioned in the binder there was some changes in the COVID-19 policy between January 2022, and August of 2023; is that correct? Am I correct in assuming that there were changes in your binder or otherwise?

A There are, yeah.

Q What were those changes to the policy and when did they occur? To ask a compound question.

A Yeah. So on December 1st, 2022, and, you know, I understand who I'm testifying for now, on behalf of the entire university, but please understand that I may not have captured all changes. This was my read of the policy changes. So on December 1st, 2022, there was a changes -- there was a change in the entities that define the health system, or UVA Health. It included adding the Monticello Surgery Center. Let

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me make sure I have the correct name. Monticello Community Surgery Center, LLC. And -- I'm sorry.

Q And what is the Bates number of the document you're looking at there?

A I'm sorry. Yeah, UVA 329. So it was the addition of the Monticello Community Surgery Center, and the removal of the Transitional Care Hospital which had been closed as a long-term care facility at that time. So there was that update.

And then also per my review, an update from that same -- well, maybe not. Let me make sure I have this right. I believe in that update was, in Appendix J, which is UVA 341, that is when the approved -- approved vaccines shall include without limitation, sort of describing the COVID vaccines available. BioNTech, Pfizer's mRNA vaccine, Moderna's vaccine, and Novavax's vaccine.

Q So the addition was the Novavax two-dose vaccine?

A I believe that was the addition. Although my recollection is in the previous versions of OCH-002, the manufacturer was not specifically

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delineated in previous versions of the policy.

Q So the policy would have referenced an approved COVID vaccine?

A Approved or authorized I think.

Q And with respect to --

A Prior to that.

Q -- your review of the policies and policy changes for your testimony today, is it your understanding that you've identified the material changes, the meaningful changes, for lack of a better term?

A Yes.

Q If -- I'm not sure which tab this is, but there's a document that is, has the Bates label UVA 13824. It's an Email message. I'll just hold it up so you can see it, and if you could find that message in your binder. It's my understanding that's in the binder. So December 22nd, 2021, Email message. It says that's when it was sent.

MS. McGRAW: You might be able to see it on the Table of Contents.

THE WITNESS: Oh, that's a good idea.

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December 22nd, 2021. Eighteen.
BY MR. DIEHL:
Q That's Tab 18 in your binder?
A Tab 18.
Q In the binder we've identified as Exhibit 21 to the deposition.
MS. McGRAW: Is that right? Did that match up to it?
THE WITNESS: Can you repeat the number?
MR. DIEHL: The Bates number is 13824.
MS. McGRAW: No, that's not --
MR. DIEHL: Actually, let's do this. Let's take a short break, and I'll do that, as there's a train, and I've got to go to the bathroom, and --
MS. McGRAW: What's the date of the document?
MR. DIEHL: I'll just show it to you. That's what I'm referring to. So -- and maybe -- it could be another exhibit I guess, but I just want to -- if it's not -- if it's not in there --
THE REPORTER: Are we off the record?
MR. DIEHL: Yeah, we're off the record.

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(Recess taken, 3:50 p.m. to 4:04 p.m.)
BY MR. DIEHL:
Q Thanks for that. We took a short break. Who's Mary Bessesen, B-E-S-S-E-S-E-N?
A I don't know. Bessesen?
Q Bessesen. Did you work closely with the Virginia Department of Health during your -- as part of your role for UVA Health in 2021, or 2020?
A I mean, closely. I worked a lot with the head Department of Health with many contacts. Yes. She --
Q Did you -- sorry.
A I'm not sure if she was at the Virginia Department of Health or not, no.
MS. McGRAW: And I'm just going to object, beyond the scope. But you can ask the questions.
BY MR. DIEHL:
Q Did the Virginia Department of the Health promulgate any rules or requirements for hospital employees related to vaccines?
A No.
Q Did the Virginia Department of Health

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promulgate any guidance for hospitals or hospital systems related to COVID vaccination in 2020 or 2021?
A Yes. So, VDH largely would reiterate CDC guidance, echo it in form, health systems, hospitals and practicing physicians.
MR. DIEHL: Um, I'm going to mark the next exhibit, and I do not remember the number.
THE REPORTER: Twenty-three.
MR. DIEHL: Twenty-three? Thank you.
(Exhibit 23 was marked for identification and attached to the transcript.)
BY MR. DIEHL:
Q Have you seen Exhibit 23 before?
MS. McGRAW: Has this been produced?
MR. DIEHL: It -- well, we can talk about it later.
MS. McGRAW: I take that as a "no."
MR. DIEHL: It's evidence in the case, is my understanding.
If it helps, I'm not trying to be smart. I believe it was an exhibit offered at the preliminary injunction hearing last July.

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MS. McGRAW: Okay. I'll take your representation for that.
A Um, I don't recall seeing this.
BY MR. DIEHL:
Q The second paragraph, do you see that begins, As you undoubtedly know?
A Yes, I see that.
MS. McGRAW: I'm going to object to the whole line of questioning as beyond the scope. It's not even a document that has been produced by UVA. It's not clear it's even part of anybody's document production at this point. You can go ahead.
A I see the second paragraph starting, As you undoubtedly know.
BY MR. DIEHL:
Q Did UVA Health leaders consider the issue referenced in that second paragraph of Exhibit 23? Did they consider that or similar issues with respect to UVA's COVID vaccination policy changes?
MS. McGRAW: Object to the form, asked and answered.
A I'm not aware that this was viewed or

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considered.
BY MR. DIEHL:
Q Well, not this specifically, but the issue described in the second paragraph, was that issue considered by UVA Health leaders at any point?
MS. McGRAW: Objection, asked and answered.
A So, if the question is was UVA, to my knowledge, did there -- were there discussions about stopping to follow CMS rules regarding COVID vaccination, um, at this time, or after, no, I am not aware that there were any discussions.
MR. DIEHL: Let's mark Exhibit 24.
(Exhibit 24 was marked for identification and attached to the transcript.)
BY MR. DIEHL:
Q I would note I don't see your name on the Email, and I believe the second page is an attachment to that Email that is Exhibit 24, but have you seen Exhibit 24 before?
A If you'll give me a second, I'll take a look at it carefully.
MS. McGRAW: And while he's doing that, I'm

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going to object, because it's beyond the scope.
A (Perusing document) Um, I don't recall seeing this document in this format. I think that I have seen similar discussions maybe just more around the number vaccinated earlier than this. But this is more detailed than has been shared with me.
BY MR. DIEHL:
Q And you're referring to the attachment, the second page that's Bates labeled 14461?
A Yes, I'm referring to the attachment, 14461.
Q And were these numbers or similar numbers part of UVA's decision-making with respect to any policy changes after November 2021?
A Um, they were not involved -- they were not discussed sort of with granularity in the discussions that I was involved with, no.
Q Were they discussed generally with respect to the number of employees that had been granted exemptions or not granted exemptions, or I guess in any general way?
MS. McGRAW: Objection, beyond the scope.

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A I'm not aware -- you know, that's such an open-ended question, I don't know. I think other than the generality of exemptions, there's an exemption process that are being eval -- exemption processes that are being evaluated.
BY MR. DIEHL:
Q So I guess bringing that back to the topics today, you're testifying with respect to the reasons and -- the reasons for policy changes with respect to UVA Health's COVID vaccination policies as that changed between 2021 and 2023, correct?
MS. McGRAW: Objection, beyond the scope, we incorporate the objections in the designations that were made for the witness.
BY MR. DIEHL:
Q Well, let me ask you this: You brought a binder with a bunch of different versions of OCH-002 to the deposition, correct?
A Correct.
Q And you did so because those policies are relevant to the topics that you're testifying about today, correct?

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A Correct.
Q So with respect to those policy changes reflected in your binder, with respect to OCH-002, were the number of employees that were exempted, not exempted, or terminated as a result of denials of exemptions, were those issues discussed generally with respect to any of the policy changes that you are here to testify about today?
MS. McGRAW: Same objection.
A And as answered previously, they were discussed in general. And what you have given me is a communication from one individual to an administrator in Employee Health and Work Med, Edward "Jack" Jackson, with others CCed, that are providing specific numbers. So, I -- you're asking me if this was shared. Was the concept and discussions around this discussed in the forums that I was discussing? Yes. Was the information as we discussed on the attachment in granular detail discussed in the meetings that I attended? I am not -- I do not recall that they were.
BY MR. DIEHL:
Q Okay. Just real quick, you talked about

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the employee -- do you know who the individuals are on the Email?

A Um, I do know some of them.

Q Who do you know who they are? And again, I guess, at this time, what was their role? I'm not asking just, you know, about them personally. Just what was their role, to your knowledge, in December 2021?

A Uh, so, Lisa Badeau is the head of the Communications Team. Jack Jackson is, at that time, an administrator in the Occupational Health Services, so Employee Health and Work Med. And then Susanna and Eric are part of the Communications Team, and I don't know Miriam Mason.

Q Or Eric Swensen?

A Oh, I said Eric.

Q Sorry.

A I said Susanna Brent and Eric Swensen are part of the Communication Team.

Q Okay. And so, I know you testified that this specific document and these specific numbers on the page Bates labeled 14461 were not discussed as

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part of your discussions about policy changes with the leadership of UVA Health. But what were you referring to when you said similar issues or general issues were discussed? I want to understand what was discussed.

MS. McGRAW: Object to the form. Go ahead.

A So this date as of December 7th, 2021, occurred --

MS. McGRAW: Twenty-seventh.

THE WITNESS: Did I say --

MS. McGRAW: Oh, I'm sorry. You're right.

THE WITNESS: Yeah. I'm sorry.

MS. McGRAW: The cover Email has a different date.

A The cover Email has a different date. But the data that is according to this line is December 7th, 2021, which was after the adoption of the required COVID vaccination, but before the booster. Actually -- I'm actually looking through this, because I didn't look to specifically see if that was addressed, but this was prior to that. It appears to me, as a, you know, a review in the number of people that were vaccinated, um, what percent that

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included in the number of individuals that had exemptions for medical reasons, and the number of individuals who had had it for -- wait, unvaccinated and not holding exemptions. I'm sorry. So the rollup of medical and religious is the third line. And then the fourth line is unvaccinated and not holding exemptions. And then it goes through on the next set of lines.

BY MR. DIEHL:

Q So maybe -- I'm intentionally interrupting, not to be rude, but just -- I'm not asking you to interpret this document. Because you didn't see this document, correct?

A Correct.

Q So you referred to, generally, similar issues or something to that effect. I'm not trying to mischaracterize your testimony. What was -- what were you referring to that was discussed?

A Yeah. And so my apologies. I'm going through this to make sure that I fully understand the data that's been -- or the document that's been presented to me.

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Q Well, if you need to read through it, let me know and you can read through it. But just when you're ready to testify about what you referred to earlier in your testimony about issues related -- related issues or related information was generally discussed. I'm not trying to put words in your mouth, I just want to understand that earlier testimony.

A Okay.

MS. McGRAW: And I maintain the objection as to form, vague and ambiguous.

MR. DIEHL: That's exactly what I'm trying to understand.

A (Perusing document) Okay. So, when I referred to sort of the overview that were discussed at this period of time, it was what fraction, what percent of our team members are fully vaccinated, which ones are not vaccinated, and what are the reasons for that? Um, because that could include individuals that have not only exempt -- you know, medical and religious exemptions, to my understanding, that would be long-term, but individuals that would also receive exemptions, because at the time of

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onboarding, for example, they could not get COVID vaccinated, or at the time of that rule. And so it's a delineation of those.

So, you know, December 2021, not a huge active area of discussion, but it would have been, we are at 97 percent, 97.3 percent, vaccinated of our health care worker workforce.

BY MR. DIEHL:

Q Did -- did -- when UVA Health leaders were talking about decisions regarding the mandating the booster or a third dose of vaccine, or subsequent policy changes until August of 2023, did the number of employees that had been terminated as a result of denials, of exemptions, did that issue come up?

A Um, they didn't come up directly with me when I was, you know, having those discussions in forums. Whether they came up in, you know, amongst Dr. Kent's executive team, I don't -- I'm not aware. I can't speak to. Um, yeah. So, I would have thought that many of the individuals who would not have accepted a primary series would also not have accepted a booster. And then most of those individuals who had

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a, finished a primary series would accept a booster. But that was not an active area of discussion that I was participating in.

Q With respect to any policy changes between 2021 and 2023, with respect to OCH-002, was there any discussion about sort of regret for losing a significant number of good workers as a result of policy mandates related to COVID vaccination?

MS. McGRAW: Objection, beyond the scope of the topics he's designated for.

A I'm not aware that there were any discussions of regret for adopting OCH-002. Amongst the leadership team or amongst my team.

BY MR. DIEHL:

Q Were you involved in the decisions related to changes in the religious accommodation procedures at any point between 2021 and 2023?

MS. McGRAW: Objection to the form, beyond the scope.

A No.

BY MR. DIEHL:

Q Did you professionally, as part of your

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work for UVA Health, study any issues related to vaccine exemptions?

MS. McGRAW: Object to the form, beyond the scope.

A I had done previous, yeah. So, um, study. There are, you know, papers and, you know, reviews regarding the exemption process. And as part of that effort, we had developed the exemption process in OCH-002 prior to the pandemic.

BY MR. DIEHL:

Q So prior to the pandemic, there was a process that was developed as part of your work?

A Yeah.

MS. McGRAW: Objection, beyond the scope.

BY MR. DIEHL:

Q OCH-002, when that changed in 2021, starting in July, that we've -- that you've testified about before, that was a change to a policy that was already in existence, correct?

A I think it was -- it was adoption as a health system policy. I think OCH is a health system policy, so it encompassed, I guess, replaced a couple

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other policies. One that was for UPG, and one for the medical center.

Q Do you know when the policy that was in effect in June 2021, do you know when that policy was adopted?

A Two thousand and nineteen. Oh wait. In -- yeah. I'm referring to my binder, but July 2019.

Q And what, what specific policy are you referring to in your binder that was adopted in July 2019?

A OCH-002.

Q And in your binder, is there a tab or a --

A Oh, I'm sorry.

Q Can you give me a tab and a Bates label to identify that July 2019 policy?

A Yes. Tab 3, and it starts with Bates label UVA 438.

Q And who were the decision-makers with respect to that adoption of that policy you just referred to in July of 2019?

MS. McGRAW: Objection, beyond the scope.

A So it was a health system policy. This

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policy was adopted by leadership team that preceded Dr. Kent. And so that would be Dr. Rick Shannon, Pam Sutton Wallace, and the rest of the leadership team.

BY MR. DIEHL:

Q Were you personally involved in decisions related to the July 2019 OCH-002 policy?

A Yes. Oh, sorry. July 2022? Did you mean July 2019?

Q I mean July 2019.

A Okay. Yes. If there was a July 2022, yeah, we can speak to that as well, but I'm not sure there is.

Q Did I misspeak? I meant to say -- well, let me just be clear. There is a July 2019 version of OCH-002 that has a Bates label -- that begins with Bates label page UVA 438. Do you see that?

A Yes. Yes.

Q And were you involved in the decisions of adoption of that July 2019 version of OCH-002?

A Yes, I was.

Q What was your role in that decision-making?

A So this is --

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MS. McGRAW: Objection, beyond the scope. Do you want to give me a standing objection?

MR. DIEHL: Sure. I don't know how it could be beyond the scope since this is the policy that was in place, but -- and you brought it in your binder. But anyway.

MS. McGRAW: I think we were very clear about -- the fact that it's in his binder doesn't mean he's going to answer a hundred questions about it. We were very clear in the designation that he was being produced to testify about OCH-002 as it existed during the 2021 time period, which is the only time period relevant to the case. But I'll take the standing objection.

BY MR. DIEHL:

Q Then let's ask about that. So this policy was in effect until this policy was adopted in July 2019, and begins with the Bates labels UVA 438, that policy was in effect in January, February, March, April, May and June 2021, correct?

A Yes, it was.

MS. McGRAW: Same objection. I mean, I'll

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take the standing. I'm not trying to interrupt you. It's just I've got to make the objection.

MR. DIEHL: Okay. Okay. Got it.

BY MR. DIEHL:

Q You -- what was your role in this, with respect to decisions regarding this policy, the 2019 OCH-002? Same standing objection.

A It was based on my recommendation to update this policy to reflect CDC guidance that had changed for Tuberculosis screening amongst health care providers. And so to expand, the material change is on -- and maybe there's others, but material change is on UVA 441 regarding Tuberculosis screening. At this time, this was a reflection that CDC's guidance changed from performing annual screening for all health care providers with, in a sort of an easy parlance, patient-facing roles, interactions where they see patients on a daily basis, to perform annual TB screening, which was the prior recommendation. But based -- so but -- so I would say but based on review of that practice, it was probably 20 years or more, the CDC revised their guidance to perform a risk

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analysis, and to -- and that institutions could then direct annual TB screening to individuals deemed to be at increased risk for TB.

Now, we went through that risk assessment. I was involved with that risk assessment. And based on that, we decided that individuals that were infectious disease physicians or pulmonologists, or other APPs, so-called nurse practitioners -- not -- so-called APPs, nurse practitioners or physician's assistants in those same disciplines, or respiratory therapists, that they were individuals at increased risk for TB exposure as a consequence of their job, and therefore, that group of individuals should undergo annual TB screening. All onboarded team members need to get TB screening on hire. What this did was reduce the TB screening requirements for most health care providers, except for the ones that I outlined in those disciplines.

Q The next iteration of policy OCH-002 is the July 2021 version, correct?

MS. McGRAW: And I'll just note for the record, and maybe I missed it, but I think you may

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have skipped the first one.
A Well, he said the one before this.
MS. McGRAW: Oh, okay.
A So if that is --
MS. McGRAW: Okay.
MR. DIEHL: Well, let me just understand, I guess, Wendy's testimony.
MS. McGRAW: I'm trying to help you out.
BY MR. DIEHL:
Q What were you just referring -- I'll come back to what I was going to ask you about, but there was an earlier version you were referring to?
A Yes. So this is not the first --
Q And I'm sorry. It's an earlier version of OCH-002?
A Correct. So July 1st, 2019, is not first version of OCH-002. The first version of OCH-002 is January 1st, 2019.
Q And what Bates label does that document begin with?
A UVA 460.
Q And -- and the change you were talking

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about with respect to that, was it TB? That was the change in July 2019?
A That was the July -- correct. That changed from January 2019 to the July -- that was the change from the January 2019 through to the July 2019 versions of OCH-002.
Q Look at the language on the second page of that January 2019 version of OCH-002, and I'm talking about the page Bates labeled UVA 461. There's discussion about exemptions. Do you see that language?
A Yes, I do.
Q And then kind of keeping that page available to you, if you could look at the, the page related to exempt -- that references exemptions on the next iteration of OCH-002. And that page I'm referring to is UVA 439.
A Okay.
Q Do you see that language related to exemptions on UVA 439?
A I do.
Q And then do you know if there was any

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changes between the exemptions or the reference to exemptions under -- between these two policies?
MS. McGRAW: Just object to the extent the documents speak for themselves. But he can answer subject to my other objections.
A I am not aware of any changes between those two statements.
BY MR. DIEHL:
Q And then what is the first page of the July 2021 version of OCH-002?
A Um, what number is it?
Q Yeah, what's the first Bates label page?
A UVA, yeah, 423. The July 2021? Yeah.
Q So I just want to get that up as well, since I don't have a binder.
A Yes.
Q The -- if you could go to the second page of the July 2021 version of OCH-002. Well, I'm looking for the -- any references to exemptions. Where are references to the -- is there a similar reference to exemptions in the July 2021 version of the policy as compared to the prev -- previous

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July 2019 version of OCH-002?
MS. McGRAW: Objection, beyond the scope. He's not here to testify about religious exemptions, and also the document speaks for itself.
BY MR. DIEHL:
Q Let me just clarify that. You understand you're here to talk about policy changes to OCH-002, correct?
A Correct.
MS. McGRAW: Objection. The designation was very specific.
BY MR. DIEHL:
Q Did you understand that general topic to be within the ambit of your testimony today?
MS. McGRAW: Objection.
MR. DIEHL: I'm asking him a question.
MS. McGRAW: It doesn't matter what he thinks. He -- what matters is what he's been designated to testify for on behalf of UVA. He's not here to give his personal opinion. He's been designated to testify about the COVID vaccine policy in effect in 2021. You can check the objections that

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are made part of the record.
A Okay. I --
BY MR. DIEHL:
Q The objections, I'm seeing that you're here to testify regarding the policy in effect in 2021, that affected and impacted plaintiffs in this lawsuit and others. And with respect to that 2021 policy, the development, formulation, establishment, and implementation of policy or policy changes. Is that your understanding?
A Yes. And I can --
Q Okay.
A And I can also clarify that the differences seen in the structure between the previous iterations of OCH-002 to the development of an appendix in July of 2021 was a process that was performed by hospital counsel that developed policy. So -- so you will notice that, that the vaccine and health care processes that were outlined in the version of OCH-002 for example, the July 1st, 2019, that we were referencing regarding the Tuberculosis screening, that those were included essentially in the narrative, I

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guess, if that's a proper word, of policy. Whereas in July of 2021, those became appendices in order to actually make the policy more clear and readable and understandable.
Q What appendix are you referring to specifically in the July 2021 version of policy OCH-002?
A So if we start on, um, page five, which has a number UVA 426, it's labeled Appendix A, that appendix is titled Measles, or secondarily titled Measles, and so it re -- you know, reviews the specific requirements, or I should not say reviews, but delineates specific requirements around measles.
Appendix B, which is on the following number, UVA 427, is Mumps and Rubella. So those are what I mean by appendices. So each vaccine preventable disease or Tuberculosis screening was in a different appendix.
Q Am I missing, does yours have a page four? Your version of this policy, the July 2021 policy?
A You are not missing it. Or at least mine does not have -- I don't have a page four either.

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Q So your -- the numbering goes from page three, which is Bates labeled UVA00 -- well, UVA 425, and then the next page is labeled page five, UVA 426? Is that your -- the way yours reads?
A That's the way mine reads as well.
Q And then it looks like on page two, there's a discussion about exemptions from the policy. Do you see that language at the bottom of page two, which is Bates labeled UVA 424?
A I do.
Q Do you know the reason for the policy change between the July 2019 policy language related to exemption requests and the exemption request information in -- the exemption request language in the July 2021 version of UVA Policy OCH-002?
A Um, my recollection I think is reflected here that there was a codification or a clear outline of the entities responsible for medical exemptions, and the entities responsible for religious exemptions.
Q What do you mean by "the entities"?
A Well, medical center hospital epidemiologist and designee would review medical

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exemptions, and then UVA HR would review applications for religious exemptions. And, um --
Q Is -- go ahead.
A And that was, I don't think clear -- I -- let's see. I am just reviewing what you showed before as to whether that was as well described in the previous iteration of the policy.
Yeah. In the other policy, it talks about providing information to Employee Health Work Med regarding medical documentation of contraindications. And then the second one doesn't -- the second line of -- I'm specifically referring to UVA 439 -- says Tier 1 Team Members, so those are team members that are on the health care -- in the health care facility at least once a year are also responsible for informing about other claimed grounds for exemptions. And so I think one of the differences between these two is saying what other claimed grounds are.
Q Is your understanding of the difference you just discussed, is that based on reading the two policies?
A No. So I know that when I was in the

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process of -- that the process of reviewing exemptions for influenza or other vaccines prior to the July 1 OCH-002, medical exemptions would come to me, and it would be determined between me and a physician in Employee Health, and other exemptions were reviewed through an HR process.

Q With requests -- with respect to requests for medical exemptions from OCH-002, did the process change in any significant way as a result of the July 2021 policy change?

A No. Not in terms of medical exemptions specifically that I can speak to. In fact, that was one of the things that we noted with considering COVID vaccine requirement for new hires when the, when that policy was changed. We, you know, spe -- at least I specifically advocated that we should use our current infrastructure for doing that process, and recommended that at the time.

Q And by "infrastructure," what do you mean?

A That exemption requests that would occur through VaxTrax, which was the electronic portal that was used for this documentation, that that would be

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sent to Employee Health, and that would be shared with me for review with, you know, an Occupational Health physician, and we made a determination as to whether that requirement, you know, met criteria for medical exemption.

Q In -- in the -- at the beginning of 2021, say in January 2021, the UVA Health had a requirement for employees to receive the influenza vaccine, correct?

A That's correct.

Q And so if an individual was a new employee and applied for a medical exemption in January 2021, with respect to the requirement of the influenza vaccine, would that process have been the same in January 2021 as the process for considering a medical exemption in, say, September of 2021 with respect to a COVID vaccine?

A Yeah. Yes.

Q And so UVA Health would apply the same standard?

MS. McGRAW: Object to the form. Mischaracterizes.

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A Um, yes.

BY MR. DIEHL:

Q Well, I mean, there was a standard that was applied. And I don't mean a legal standard. I mean, there was some criteria for granting or denying an exemption, correct?

A Yes. Between those two dates, yes.

Q And you personally -- well, you were the medical center hospital epidemiologist? Is that correct?

A That is correct.

Q And you mentioned something about you advocated for the same process. I'm not trying to put words in your mouth, but what did you say about the exemption process with respect to the addition of COVID vaccination?

A I'll take a step back, but -- and just say that when there were discussions about COVID vaccination as a requirement, as, you know, a requirement for work, that I advocated for its inclusion under the structure that we had developed for other vaccine requirements for work. And so those

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are the policies within OCH-002, but also the infrastructure of tracking that. Now, there were opportunities to improve that, you know, but yeah.

Q But in general, you advocated for the same process, procedure, personnel? Is that fair?

MS. McGRAW: Objection, mischaracterizes.

MR. DIEHL: Well, I'm trying to understand.

MS. McGRAW: It's asked and answered.

A Well, from the medical exemption standpoint, I advocated that medical exemptions be handled the exact same way that we do influenza vaccinations.

BY MR. DIEHL:

Q Were there any decisions made with respect to the policy changes at UVA Health by the leadership to change either the medical exemption or the religious exemption process?

MS. McGRAW: Objection, beyond the scope. We've made clear he's not here to talk about the religious exemption process.

A So no changes for the medical exemption process.

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BY MR. DIEHL:
Q I'm talking about decision-making with respect to changes in the policy itself.
MS. McGRAW: Object to the form.
BY MR. DIEHL:
Q Was there a discussion about changing the policy resulting in changes to either the medical exemption or the religious exemption process?
MS. McGRAW: Object to the form.
A So again, I can speak to medical exemption process. Well, no change to either that I'm aware of, and no structural change to the mechanism and the practice of medical exemptions for influenza and COVID, and other vaccines.
BY MR. DIEHL:
Q So with respect to Topic 4 on Exhibit 20, the subjects of the deposition, it's my understanding that subject to -- tell me when you've got that in front of you. I don't mean to --
A Yeah, thank you. Four?
Q It's page six of Exhibit 20 is where Subject 4 or Topic 4 is listed.

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And then if you could go to Defense Exhibit 2, and the -- thank you -- and the second page of that, just to kind of have those two in front of you.
A Okay.
Q And if you could -- do you see your name there next to, next to number one?
A Yes.
Q And then it says, Topic 4 as it relates to medical exemptions. What is your understanding of what you're to testify about with respect to Topic 4 on Exhibit 20?
MS. McGRAW: Object to the form. It calls for legal discussions with counsel. Objection to the extent it's attorney-client privilege.
MR. DIEHL: Anything else?
MS. McGRAW: Yeah. I mean, he can -- I don't want him to answer with --
MR. DIEHL: I'm not asking about discussions with counsel. I'm asking about your understanding about that subject and topic.
MS. McGRAW: Understanding that you didn't

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get from counsel.
MR. DIEHL: Well --
MS. McGRAW: You can ask him questions.
BY MR. DIEHL:
Q You're prepared to testify about that topic, correct?
A I'm prepared to testify about that topic.
Q Okay. What topic did you prepare to testify about?
A Through the evaluation process of medical exemptions.
Q But the topic refers to differences in the process. What's your understanding of differences between the medical exemption process as compared to the religious exemption process?
MS. McGRAW: Objection, beyond the scope. He's not here to talk about the religious exemption process. You just had him review the designation, which very clearly said he would tell you what the mech --
MR. DIEHL: So how am I supposed to get an understanding of the differences if he doesn't know

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what the differences are, and the other witness is not going testify about the medical process? So neither of them are going to talk about the differences? Okay. I'm not understanding.
MS. McGRAW: You can determine that -- you can find out what the process was, and then you can compare them. They're not going to compare them for you. He's here to testify about the medical exemption process. You can ask your questions about the medical exemption process. He's not going to do a comparison.
BY MR. DIEHL:
Q Walk me through the medical exemption process as it existed in -- well, throughout 2021, did the medical exemption process change?
A It did not.
Q So walk me through the medical exemption process in 2021.
A So in 2021, if a person submitted a request for a medical exemption process, that would be done through VaxTrax. They would be instructed to, you know, state the request, why they have a medical exemption. They would be provided, actually in that

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electronic product, as I recall, a link to CDC guidance regarding contraindications and precautions around influenza vaccination -- and I'm sorry, we're talking about COVID vaccination, but it was the same process -- and guidance that they would, to get a letter from their health care provider regarding their specific medical, you know, contraindication to said vaccination, COVID or influenza. That electronic document would be uploaded to VaxTrax where I would review it in collaboration with, again, another physician, that's Dr. Josh Eby, or Joshua Eby in Employee Health, and we'd make a determination as to whether that medical exemption request was supported by CDC guidance, ACIP guidelines, or whether it did not.

Q How do you spell Dr. Eby's last name?

A E-B-Y.

Q And what -- were employees required to provide some sort of documentation from a medical provider with respect to contraindications or conditions that might -- that they believed prevented them from vacci -- or receiving the COVID vaccine?

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A Yes, that is correct.

Q And so, for example, if an employee had requested a medical exemption and they didn't include the, any information from a medical provider, what would happen then?

A They would be returned to the employee saying, You need to include a letter from your health care provider regarding your request for a medical exemption.

Q What about a -- well, were there any situations in 2021 where an employee's medical provider provided information, but it wasn't clear enough, or there wasn't certainty as to what the provider was saying?

A Yes, there were occasions. In 2021? That has occurred over the years of this process, and I think I'm con -- I'm confident that it occurred in 2021, yes.

Q And would you indicate -- in any response to the employee, would you indicate what information was missing or should be provided to make a determination whether this, the exemption request

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could be granted or not?

A Yes, we would -- you know, each situation was different, but we had occasion to say we don't have enough information from this, from your provider. Can you have them provide more information?

Q Was that true with respect to any issue where there might be a deficiency in the information provided, but -- you know, the information might exist or the provider might be able to provide the information, but you just -- it just wasn't there. Would you make a -- would you inform the employee of what information was missing?

MS. McGRAW: Objection, incomplete hypothetical, calls for speculation, but you can answer.

BY MR. DIEHL:

Q Well, do you understand the hypothetical I'm referencing?

A I understand the hypothetical, and I can testify. Again, maybe not specifically in 2021, but yes, we've had to, you know, make those requests. Can you provide specific -- specifically more information

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on, you know, a certain medical topic.

Q Is there a -- sorry. Didn't mean -- is there a reason you would do that as opposed to just saying, Your request is denied; you can resubmit if you want?

A Because -- yes. And the reason was, was that some of them, when we would ask for clarification, they could meet the criteria for a medical exemption. But the information provided was not clear. There were some that would not meet, and we were able to say, you know, Sorry, but your exemption request is not approved. It is not a CDC contraindication to vaccination.

Q So -- so in those situations where an employee might be able to provide additional information, or the provider might be able to provide additional information, it was only fair to inform the employee of what was missing; is that correct?

MS. McGRAW: Object to the form.

A Um, I think it's fair. We were also -- we want to have people who, you know, are working, yeah, so we would work with them to, you know, if there was

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unclear information from their health care providers -- from their, yeah, exactly, health care providers. The health care provider's primary care provider. And just to be clear, it's sometimes because that primary care physician would provide no information, or just a signed document saying, Approved -- you know, I think approved, you know, meets criteria. And we actually needed the information, request the information as to why they met criteria for having a medical exemption.

BY MR. DIEHL:

Q In -- at any point between January 2021, and just to bookend, December 2022, so that two-year period, did UVA Health prohibit visitors from seeing patients in -- that were being treated by UVA Health?

A Yes.

Q What period of time was that?

MS. McGRAW: Objection, beyond the scope.

A It was a broad question. So there was a lot of reasons that vis -- you know, that visitors may not be allowed to visit. If those visitors were known to have COVID, they were not allowed to visit. If the

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visitors were visiting a COVID positive patient, those visitors could not see those COVID positive patients, except out of exception with a health care team, usually in collaboration or at least request of review of myself or somebody on my team. And then finally -- well, I shouldn't say finally. I anticipate there were other restrictions -- during this period of time, there certainly were other restrictions around age. You know, so people young of age may not have been allowed to visit portions of that period of time. And then finally, around the time of the omicron surge, there was a period of time that was on the order of several weeks or a couple months where there were no visitors except, except out of exception.

BY MR. DIEHL:

Q And when was that period of time when no visitors other than exceptions were allowed?

A January and February 2021. Sorry, 2022. January, February 2022.

And then finally, not to belabor this, but at times there were -- there were restrictions without -- that there were more defined. So there is

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a visitor status called "designated visitors." And so those are visitors that are spelled out by the patient that says, This is a person that is, you know, important for their care of me, and those individuals often spent the night in the hospital. So a common example, for example, could be a spouse or a parent that stays in the hospital. And so there were -- would be at times where a designated visitor was allowed, but a regular visitor, for lack of a better word, was not, or they had shorter visitation hours.

Q Um, the designated visitor, that issue, or that limitation, was that related to COVID and limiting visitors because of the COVID virus?

A Yeah. Yes.

Q And other than the period of January and February 2022, some visitors were allowed for patients other than perhaps patients that had COVID -- or excuse me, visitors that had COVID or visitors that might be trying to visit someone who had COVID themselves?

A There was so much going on, there may have been other times when more heightened restrictions of

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visitors occurred. But to my recollection, that was the only period of time where we said no visitors. And I'll also say, I said January, February. It may have extended longer or shorter, but it was a period of time within that significant certain strain during omicron.

Q So it might have been two months, but it probably wasn't longer than three months? Is that fair?

A I -- to my recollection, it wasn't longer than three months. I actually think that it may have been shorter than that. But again, my memory is -- may be a little bit fuzzy around that detail.

Q Was -- did UVA Health ever impose any limitations on employees out -- activities outside of work for the purpose of limiting their exposure to COVID?

A Um, yes. The one that comes to mind were travel restrictions with faculty. So faculty were not, I don't want to say not allowed, but there was a process where travel was restricted. The way that manifested was university-approved travel, so you

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think about people going to national conferences or international trips, much of that was, you know, curtailed or went through an approval process, certainly in 2020, and I think at times in 2021.

Q Other than faculty travel, were there travel restrictions on any other employees of UVA Health related to COVID?

MS. McGRAW: Objection, beyond the scope.

A Not that I recall.

BY MR. DIEHL:

Q So with respect to safety preventive measures in response to COVID-19 -- well, I just said COVID-19 instead of COVID. Did the COVID-19 get dropped at some point? I'm just sort of -- this is just maybe beyond the scope. I'll object as beyond the scope.

MS. McGRAW: Thank you.

BY MR. DIEHL:

Q Did the term COVID versus COVID-19, did that -- is there a difference in that?

A There's no difference in that. I think people just dropped the 19 because it's easier. But

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the disease designation by the, I think it was the World Health Organization, but I may be wrong, was COVID-19, reflecting that there may be other coronaviruses that cause outbreaks during other years.

Q And with respect to any activities or issues outside the workplace, did -- from January 2020 to the present, do you know of any preventive measures or preventive policies that UVA Health adopted or implemented for employee activities outside of work, other than the travel issue related to faculty you just mentioned?

MS. McGRAW: Objection, beyond the scope.

A So the question was towards policy, and that's the one policy that, off the top of my head, I can think of that sort of fits within what you were describing. There was a considerable amount of education that occurred during this period of time with things like, You may want to consider things like elective travel. You may, if you're to do that, be -- you know, measures to protect yourself while traveling on airplanes, in airports, on public transportation.

You know, at some point, there was -- and I

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can't say when that was, but there -- it would certainly come up that after travel, employees may seek out, you know, COVID testing after their return. And this was certainly probably more of an issue, I think, that occurred in 2020 than some of the time frame you've been laying out in 2021 and 2022. But you know, some of those practices I think were still occurring.

In addition, sort of the general counsel, being aware of COVID in your community, potential risks for COVID, and, you know, ways to mitigate risk. You know, having dinner parties outside, opening up windows, all those types of things were discussed and counseled, and, you know, questions that came up during educational sessions.

BY MR. DIEHL:

Q With respect to transmission of COVID, or -- excuse me. Let me start that over.

With respect to employees of UVA Health that contracted COVID, did UVA undertake any effort to determine how often that occurred outside of work versus how often that might have occurred at work?

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A Not like in a running tally type of way, because it was very difficult to tell. You know, however, anecdotally, it seemed that we saw more transmission that occurred in the community than we saw in the hospital, especially once we had, you know, you know, some of the efforts around admission testing for COVID patients, universal masking, and those types of mitigation efforts.

MR. DIEHL: Let's take a quick, a quick break.

(Recess taken, 5:04 p.m. to 5:12 p.m.)

BY MR. DIEHL:

Q We talked earlier about a gentleman who had -- who you talked to in preparation for today, who has responsibilities related to contractors or those types of issues?

A Right.

Q What was his name?

A Adam Momper.

Q And your personal duties don't involve managing contractors or contracts relationships for UVA, do they?

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A They do not.
Q So Mr. Momper would have a better day-to-day understanding of UVA's relationship with contractors and their workers that are at UVA than you? Fair?
MS. McGRAW: Objection, beyond the scope.
A Yes.
BY MR. DIEHL:
Q Is there anyone else, to your knowledge, at UVA, that has day-to-day responsibility for either overseeing contract relationships or contract worker relationships at UVA?
A So Jack Simpson is a person that comes to mind, but he reports to Adam Momper. So I think they're like in the same office, but Adam is the administrator of that office.
Q Is -- sorry, go ahead.
A And I was going to say, you know, there's a group of, of team members, of health care providers that we consider, or at least -- and we have always, "we" being my office, Hospital Epidemiology and Infection Prevention and Control have always

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considered to be part of our family. They're day-to-day employees, health care worker, frontline providers. I'm specifically talking about our housekeepers and our food and nutrition workers. They get their health care -- their employee health care through Employee Health. We sort of treat them as UVA employees even though they're, you know, they're there -- I guess, under the name as, I think, contract vendors.
Q So they're paid by somebody else, but they're in UVA Health's facilities, providing services to UVA patients?
A Yeah, correct. And visitors. Like, for example, with, you know, food and nutrition, you think about the cafeteria. And I am not certain, but I don't believe, that they report through Adam Mompar.
Q Would those workers that you were just referring to, would those be given direction by nurses or workers, UVA Health workers in those areas?
MS. McGRAW: Objection, beyond the scope.
A You know, they have their own reporting chain and reporting that goes up to the Chief

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Operations Officer, and so there's a Hospitality Services Director and that's who oversees those, those groups. They certainly work in collaboration with nurses and administrators.
BY MR. DIEHL:
Q Who's that person that you referenced, the -- I forgot the name.
A Chief Operating Officer.
Q Well, the person that is responsible -- the UVA leader that's responsible for those workers I guess, or those -- whatever you just said.
A I guess Min Lee is the COO, the Chief Operations Officer. And then -- is that who you were asking about? Because I also brought the administrator who is hospitality.
Q Can I look back? I just -- there was -- can we just pause for a second off the record?
MS. McGRAW: I think he said Hospitality Services Director.
A Which is not the right term, but --
BY MR. DIEHL:
Q Do you recall -- who are you trying to

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refer to, I guess, when you said Hospitality Services Director?
A Bush Bell.
Q How do you spell that?
A Bush is B-U-S-H; Bell is B-E-L-L.
Q And do you know what his or her title is?
A Clearly, I don't have a strong grasp on it, but it's Hospitality and Ancillary Services or something along those lines, yes.
And I should also caveat that in my role, I'm not entirely certain that that's exactly correct, although I think he's usually in those conversations. I think that they do report to him, but I really -- don't view me as an expert on that management structure process.
MR. DIEHL: No further questions.
MS. McGRAW: Just a couple of follow-ups for clarity.
EXAMINATION BY COUNSEL FOR DEFENDANT THE RECTOR AND VISITORS OF THE UNIVERSITY OF VIRGINIA
BY MS. McGRAW:
Q Adam Momper, do you know if he manages

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contractors versus vendors?
A Vendors. I know he manages vendors.
Q Okay.
A Yeah. Thank you. I think contractors is, yeah, the proper name for EVS and food and nutrition, which are Crothall and Morrison.
Q And can you give an example of what we mean by a vendor in the hospital context?
A Yeah. So a vendor could be an individual that is in the health system providing, you know, equipment, or, you know, like telephone lines, or photocopiers, but also health care associated products. Things like implants, artificial knees, artificial joints, and, you know, they service UVA and maybe have another hospital or two that they go to.
Q And you were asked a lot of questions about the medical exemption process for the flu vaccine and the COVID vaccine. Were -- were the criteria, like what would actually qualify as an exemption, the same under both the flu vaccine and the COVID vaccine?
A No. Because the contraindications to vaccination for flu and for COVID are different. The

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parallel is that we would follow CDC guidance saying What is a medical contraindication to this vaccine? So --
Q In terms of the review during the COVID medical exemptions, you mentioned Dr. Eby. Were there ever any nurse practitioners involved in the review process?
A I think that there was an initial process, like, to make sure that the vaccine, that the exemption letter was attached -- sometimes that didn't come through -- or if there was an exemption and we had gotten to the point of stipulating of what is not qualifying as a medical exemption. If it met those criteria, I think those were -- my understanding is those exemptions were dismissed -- or not dismissed -- were not approved or didn't come to us, because they, you know, they were already on the this-does-not-count -- pregnancy or something like that, as an example.
Q And was that just with respect to the COVID vaccine?
A That was with the flu vaccine as well, to

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my recollection, yeah.
Q Okay. And is that a proc -- the use of the nurse practitioners and the list of things that weren't going to be recognized, is that -- is that something that started in 2021?
MR. DIEHL: Objection, vague.
A It started before 2021.
BY MS. McGRAW:
Q Okay.
A I'll add that I don't think it's been a continuous process, because some of those nurse prac -- for a while, we had no nurse practitioners. So they would all come to us without filter.
MS. McGRAW: Okay. Those are the only questions I had.
MR. DIEHL: I have a couple follow-ups.
EXAMINATION BY COUNSEL FOR THE PLAINTIFFS
BY MR. DIEHL:
Q With respect to, I think you said contraindications that would qualify an individual for a medical exemption, um, did UVA -- well, I want to ask about those. And I'm going to ask about the time

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period of January, or -- yeah, January 2019 through the present. Did UVA always follow whatever the CDC's guidance was with respect to medical contraindications for either the flu vaccine or the COVID vaccine medical exemptions?
A Yes.
Q And do you recall any time where UVA Health decided to depart from CDC guidance with respect to medical contraindications during that time period?
A No. Um, the reason I'm hesitating is there are examples -- I'll give you this example. This is a good one. And I'm sorry to belabor this, but I just want to be accurate. So for flu vaccine, there are individuals that claim -- or request a medical exemption for an egg allergy. The CDC does not consider an egg allergy to be a contraindication to flu vaccination, including flu vaccines that are produced in eggs. I believe they used to, but that is not considered to be an exemption now. We, um, rather than say that is not a medical exemption, we direct those team members to say we have an alternative product that's called the Flublok that's not produced

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in eggs, but it's produced in insect cell line, called S2 cells. And so that protein vaccine called the Flublok, F-L-U-B-L-O-K, can be given to individuals regardless of egg allergy, but this is a way for us to provide a vaccine to team members who are concerned about egg allergies.

Last year, that vaccine was not available, um, because of a production problem. And my recollection is that for that year, we allowed egg allergy exemptions, even though the CDC does not recognize them. So, that's a place where we departed from CDC contra -- listed contraindications for influenza vaccines.

Q With respect to the medical exemptions granted after July 2019 with respect to the COVID vaccine, do you know approximately how many medical exemptions were granted for UVA Health employees with respect to the flu -- I did it. Let me step back.

So I'm asking about the time period of July 2021 through the end of 2021 with respect to medical exemptions granted with respect to the COVID vaccine. Do you know how many medical exemptions were

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granted by UVA Health during that period?

A I'm not entirely certain about that time frame, if it aligns, but I believe around 20, 21 medical exemptions were granted during that period of time, or approximately that period of time.

Q Was there ever a process by which someone that had a medical contraindication with respect to the influenza vaccine would be automatically granted an exemption with respect to the COVID vaccine?

A There was not.

MR. DIEHL: No further questions.

MS. McGRAW: Okay. We're done. We have the -- you have the right to read and sign the deposition, and we recommend that you do that. So if you'd tell the court reporter that.

MR. DIEHL: I don't know that he does have -- I'm just joking.

MS. McGRAW: He does not waive. We would like to read and sign.

THE WITNESS: I do not waive. I will read and sign.

THE REPORTER: Can I get you to state your

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transcript orders, please?

MR. DIEHL: I would like to order a transcript. Actually, no. I would like the transcript in one week.

THE REPORTER: So by next Thursday you want that?

MR. DIEHL: Yeah.

MS. McGRAW: Once he pays for the expedite, does that mean I get it, or do I still have to pay for the expedited?

THE REPORTER: If you want it early, you --

MS. McGRAW: I don't think I need it expedited. Just regular turnaround. But I would like the full transcript and a mini version, just electronic.

MR. O'MALLEY: We would also like a copy.

(Off the record, 5:26 p.m.)

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CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

I, Michelle L. Lonas, RPR, CCR, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting by me; that reading and signing was requested; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 11th day of September, 2024, in Shenandoah County, Virginia.

Michelle L. Lonas, Notary Public #169569
Commonwealth of Virginia at Large
REGISTERED PROFESSIONAL REPORTER
CERTIFIED COURT REPORTER #0313254

My commission expires on the 31st day of May, 2027.

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